

Paying the Price of War:  
United States Soldiers, Veterans, and Health Policy, 1917-1924

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## **ABSTRACT**

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During eight turbulent years in the World War I era, policy makers, soldiers, and veterans laid the groundwork for the extension of government sponsored medical care to millions of former service members. In the process, they built a pillar of the American welfare state. Legislation and rehabilitation plans formulated shortly after the U.S. entered the Great War aimed to minimize the government's long-term obligations to veterans, but within less than a decade, those who had served gained conditional access to their own direct assistance agency and a national system of hospitals. This dissertation explains why that drastic transition occurred, and how one group of citizens won the right to obtain publicly funded health services. The story of wartime health policies has a variety of larger implications. It shows how veterans' welfare shifted from centering on pension and domicile care programs rooted in the nineteenth century to the provision of access to direct medical services; how rehabilitation and citizenship rights were conceived of and perceived at the dusk of the Progressive Era; how race, class, and gender shaped the health-related experiences of soldiers, veterans, and caregivers; how shifting ideals about hospitals and medical care influenced policy; and how interest groups capitalized on the tense political and social climate to bring about change. On a general level, an examination of the roots of a nationwide veterans' hospital system demonstrates how privileges were won in the twentieth century United States. It reveals a moment of state expansion, but it also illustrates the wider tendency of the U.S. government to award entitlements selectively. Given those factors, the policies that paved the way for the advent of a veterans' medical system deserve to be considered – alongside later federal assistance programs such as Social Security, Medicare, and Medicaid – as foundational in the development and shape of the American welfare state.

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## **ACRONYMS**

AEF: American Expeditionary Forces

AHA: American Hospital Association

AL: American Legion

BWRI: Bureau of War Risk Insurance

CND: Council of National Defense

DAV: Disabled American Veterans

DPR: Department of Physical Reconstruction (U.S. Army)

FBH: Federal Board of Hospitalization

FBVE: Federal Board for Vocational Education

OT: Occupational therapy

PHS: Public Health Service

VA: Veterans' Administration

VB: Veterans' Bureau

WRIA: War Risk Insurance Act

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## INTRODUCTION

### Medical Welfare and the Great War

The transition was remarkable. In September 1917, as millions of Americans mustered into service and the nation's army and industry mobilized for war, hopes were high. "Science to Rebuild Our War Cripples," boasted a *New York Times* headline. Military hospitals would heal and re-educate each wounded soldier, the newspaper reported, then "return him to civil life ready to be as useful to himself and his country as possible."<sup>1</sup> Approximately two years later, it was clear that things were not going according to plan. Some soldiers were not being returned to "civil life ready to be... useful," but instead remaining in government hospitals and "receiving treatment that cannot be justified by anyone who has any regard for the well being of the men who fought to maintain the country."<sup>2</sup> By 1923, early wartime hopes had come full circle. There had been "huge waste" in the expenditure of hundreds of millions of dollars on hospital care for those who served during World War I, the *Washington Post* reported. The money had been "loosely spent" and "lavished with only the vaguest sort of plan."<sup>3</sup> In the shadow of that realization, the government moved forward in the early 1920s with the creation of a vast veterans' hospital system, which would ensure that former service members – even in "civil life" – would have access to publicly funded hospitals.

From 1917 through 1924, policy makers, soldiers, and veterans laid the groundwork for the extension of government sponsored medical care to millions of people. In the process, they

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<sup>1</sup> "Science to Rebuild Our War Cripples," *The New York Times* September 17, 1917.

<sup>2</sup> "Bad Treatment of Sick Soldiers," *The Atlanta Journal-Constitution* January 28, 1920.

<sup>3</sup> "Charge Huge Waste in Hospitalization," *The Washington Post* March 21, 1923.

built a pillar of the American welfare state. World War I-era policies shaped military and veterans' health care for the greater part of the twentieth century, and underpinned the 1921 creation of the Veterans' Bureau (VB), one of the nation's first and most enduring direct assistance government agencies. In 1924, all ex-soldiers – not just those harmed in the line of duty – gained legal access to the veterans' hospitals overseen by the VB. The guarantee of medical care for veterans provided allowances for some of those who made extreme personal sacrifices. It also instantiated and furthered the precedent that, in the U.S., state-sponsored privileges could be earned not by national birthright, but by virtue of membership in a definable group.

Medical treatment for U.S. military personnel and veterans was not expanded strictly by virtue of an unbridled societal commitment to “care for him who shall have borne the battle,” as Abraham Lincoln said in his second inaugural address. Indeed, for many months after President Woodrow Wilson similarly proclaimed, in the winter of 1918, “this nation has no more solemn obligation than healing the hurts of our wounded,” the government struggled to come to terms with its self-declared responsibility.<sup>4</sup> A calamitous situation resulting, in part, from pre-war planning oversights, as well as vigorous political lobbying rooted in widespread anti-radicalism and expanding expectations of professional medicine, led to the creation and growth of a federally sponsored hospital system for veterans.

### *The story and its significance*

In the months surrounding the United States' declaration of war in April 1917, government officials and medical professionals readily acknowledged that wounded and ill

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<sup>4</sup> "President Wilson's Message on Healing the Hurts of Our Wounded," *The Come-Back* December 24, 1918.

soldiers were an inevitable consequence of raising an army. But they attempted to de-emphasize the reality that war had the potential to turn industrially productive citizens into dependents by stipulating that major medical rehabilitation work would be overseen entirely by the military. By the time soldiers were discharged as civilians, the rationale went, they would be fully self-reliant. The 1917 War Risk Insurance Act guaranteed that ex-soldiers could receive necessary medical services after being released from service, but failed to define who would manage and fund those services.<sup>5</sup>

The oversight was massive, especially considering the number of people who served in the war – and were therefore eligible for future care.<sup>6</sup> A review of statistics regarding military diagnoses and treatment provides a picture of the most common ailments, as well as the diverse

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<sup>5</sup> Section 302 of the Act stipulated that, “the injured person shall be furnished by the United States such reasonable medical, surgical, and hospital services and supplies, including artificial limbs, trusses, and similar appliances, as the director (of the Bureau of War Risk Insurance) may determine to be useful and reasonably necessary.” It contained little explanation of how these ideals would become reality. An Act to Amend an Act Entitled ‘an Act to Authorize the Establishment of a Bureau of War Risk Insurance in the Treasury Department,’ Approved September Second, Nineteen Hundred and Fourteen, and for Other Purposes, Public Law 90, H.R. 5723, 40 Stat. 398, Sixty-Fifth Congress, First Session, (Washington, D.C.: Government Printing Office, October 6, 1917).

<sup>6</sup> This dissertation focuses mainly on the army (and, by extension, soldiers), since that is the military branch that mobilized the highest number of personnel, and that the federal government relied on to provide the bulk of rehabilitation services. Between April 1917 and December 1918, the U.S. Marine Corps grew from 13,725 to its peak wartime strength of 75,101 officers and enlisted personnel. Although marines were “essentially part of the Naval establishment,” and as such had access to Naval hospitals, there were only six such hospitals in the U.S., overseen by a relatively small Navy Medical Corps. Both at the front and in the U.S., some marines and sailors were treated in army hospitals. Edwin N. McClellan, *The United States Marine Corps in the World War* (Washington, D.C.: Historical Branch, U.S. Marine Corps, 1920). The official army order allowing navy personnel to be treated in army reconstruction hospitals was handed down on May 27, 1918. A.G. Crane, *The Medical Department of the United States Army in the World War; Volume 13, Part One: Physical Reconstruction and Vocational Education*, ed. M.W. Ireland (Washington, D.C.: Government Printing Office, 1927), 39. The Navy experienced tremendous growth during World War I, expanding from 67,000 in service in April 1917 to nearly 500,000 in November 1918. John Lehman, *On Seas of Glory: Heroic Men, Great Ships, and Epic Battles of the American Navy* (New York, New York; London; Toronto; Sydney; Singapore: The Free Press, 2001). The Coast Guard contributed 15 cruising cutters, 5,000 enlisted men, and 200 officers to the Navy during the war. Thomas P. Ostrom, *The United States Coast Guard and National Defense: A History from World War I to the Present* (Jefferson, North Carolina; London: MaFarland & Company, Inc., Publishers, 2012), 14. Between April and August 1917, the ranks of the National Guard swelled with incoming volunteers, from 177,000 members to 377,000. On August 5, 1917, President Wilson drafted the guardsmen into service, at which point they became members of the U.S. Army. John K. Mahon, *History of the Militia and the National Guard* (New York; London: Macmillan Publishing Company; Collier Macmillan Publishers, 1983), 156. Eventually, veterans of all branches were eligible for government sponsored medical care.

needs and backgrounds of troops. Of the approximately 4.3 million service members mobilized between April 1917 and December 1919, 204,765 were eventually discharged as physically or mentally unfit for military duty. More than 80 percent, or about 169,000 of them, were discharged due to disease.<sup>7</sup> Tuberculosis was the most common war-time disease, constituting approximately 21,600 discharges. More than 10,000 service members were discharged for “mental deficiency,” the second most common ailment.<sup>8</sup> About 12 percent, or 25,000 service members, were discharged with a disability due to wounds received in action. The great majority of the latter group – 86 percent – had sustained gunshot wounds; slightly more than 11 percent were victims of poisonous gas, which could cause long-term ailments ranging from respiratory problems to skin burns.<sup>9</sup> In all, approximately 224,000 U.S. Army troops were wounded in action during World War I, in addition to almost 10,000 Marines. Almost 52,000 of those service members went on to receive further care in domestic military hospitals.<sup>10</sup>

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<sup>7</sup> Albert G. Love, "A Brief Summary of the Vital Statistics of the U.S. Army During the World War," *The Military Surgeon* Vol. LI, Number 2(August 1922): 147-48. A great majority of the soldiers discharged due to disease had never left the United States; see Chapter Two for a discussion of this issue, and a further description of wounded and ill soldiers.

<sup>8</sup> Diagnoses and classifications of psychological conditions varied greatly throughout the war. “Mental deficiency” fell under the general category of “mental alienation,” which also included diagnoses such as “psychoneurosis” (for which approximately 2,000 service members were discharged) and “constitutional psychopathic states,” (which constituted approximately 3,700 discharges). Ibid.: 166-89. Annessa Stagner has pointed out that estimates of those discharged with shell shock range from 15,000 to 76,000, which she attributes in part to “the ambiguity regarding the meaning of shell shock.” Annessa Stagner, "Healing a Soldier, Restoring the Nation: Representations of Shell Shock in the United States During and after the First World War," *The Journal of Contemporary History* (Forthcoming). Later chapters of this dissertation will discuss the fact that, in the 1920s, providing enough hospital beds for veteran-patients suffering from psychoneurosis and related conditions proved a great challenge, and helped pave the way for an expansive veterans' hospital system.

<sup>9</sup> Love, "A Brief Summary of the Vital Statistics of the U.S. Army During the World War," 147-48.

<sup>10</sup> Ibid.: 165. According to Love, the number of soldiers treated at some point during their service for illness or injury was extremely high: Between April 1917 and December 1918, the Army Medical Department admitted about 2.57 million patients to the sick report. 2.4 million of them were serving in the U.S., while 873,816 were serving abroad.



During and immediately after the Great War, some of the patients with the most complex medical needs were sent to Walter Reed Army General Hospital, where they became part of a burgeoning military medical system. The turn of the twentieth century marked a period of accelerated change in the history of military health care in the United States. Wounded and ill troops had long received first aid on the battlefield or in rudimentary field and camp hospitals that was aimed primarily at returning them intact to their units. But beginning in the 1890s, as the military mirrored and built upon trends evident in civilian society, soldiers were treated in large-scale permanent army general hospital complexes with multi-faceted and complicated missions that extended well beyond the provision of medical care. These institutions – Walter Reed Army General Hospital among them – helped lay the foundations of the modern army health care system.

The immediate effect of pre-war policies aimed at guaranteeing that soldiers would be discharged as fully healed civilians were most evident at institutions such as Walter Reed, where the army implemented sweeping rehabilitation measures that included services such as occupational, physical, and vocational therapy. The rehabilitation project at Walter Reed was presented and perceived in a variety of ways. Army representatives portrayed military hospitals as camp-like sanctuaries of learning, healing, and growth. Some patients and their relatives, on the other hand, complained that care and conditions at the institutions were sub-par.

Regardless of perspective, it soon became evident that, for many, military hospitals would serve as mere starting points on a long path of institutional care. By the winter of 1918-1919, government officials increasingly paid heed to claims from both soldiers and bureaucrats that the pre-war hope of rehabilitating service members under the auspices of the military was unrealistic. Injured and ill soldiers, as well as temporarily enlisted medical personnel, opted for

hasty discharges rather than prolonged hospital stays. At the same time, some ex-service members argued that they were being discharged from the military before they were fully capable of taking care of themselves. All the while, soldiers and veterans increasingly came forward with latent war-related ailments such as tuberculosis and mental illness. Throughout 1919, Congress acknowledged that the rehabilitation project would have to go beyond the purview of the military, and dictated that multiple government agencies work together to provide medical services for an ever-increasing number of veterans. Even as more funding was allocated for veterans' medical care, those agencies struggled to define areas of jurisdiction and standards of treatment.

Meanwhile, as soldiers were discharged from service, they joined a number of organizations that served as both social networks and political advocacy forums. Two such groups, the American Legion and Disabled American Veterans (DAV), made the fight for access to government-sponsored health services central to their agendas. The Legion and DAV advocated for injured and ill veterans because they were being mistreated. But, in lobbying for increased government services, the groups' leaders also hoped to stave off political radicalism among seemingly vulnerable ex-service members. Even as they claimed all veterans were a class apart, both the American Legion and DAV allowed state chapters to adopt their own policies regarding whether or not ex-soldiers of color could be accepted to the organizations, fought in Congress against the integration of both military and veterans' hospitals, and adopted anti-immigrant platforms. The groups' policies – adopted in the wake of intra-organizational disagreements about the virtues of egalitarianism – showed that the priority of gaining benefits for white, male veterans took precedence over gaining benefits for all veterans. Although steeped in the social milieu of the time, the tactics of the American Legion and its counterparts were

highly effective. By the early 1920s, the groups counted members of Congress among their ranks, and they wielded great political power.

By the time veterans' advocates proposed the re-organization and expansion of veterans' hospital care, government officials and professionals involved in the system were open to change. They were eager to alleviate the effects of previous attempts to coordinate services of various government agencies, which had been largely unsuccessful and brought about a chorus of charges of neglect. In August 1921, following a build-up of frustration with bureaucratic insolvencies and amidst increasing veterans' activism, the Veterans' Bureau was established. Later, enhanced funding for veterans' health care, the overall expansion of medical institutions for ex-soldiers, and further advocacy efforts led to the creation of a congressional committee specifically intended to review and help pass legislation pertaining to World War veterans. It helped usher into law a measure stipulating that all veterans – not just those who had incurred injuries and illnesses in the line of duty – should have access to free medical care. Former service members were thus granted access to institutions as a reward for their membership in a newly powerful interest group of citizen-veterans.

This dissertation tells the story of how and why veterans were granted special rights, but it pays heed to the fact that those rights were offered first and foremost to white, male veterans, and that the extent of them ebbed and flowed over time. During and immediately following the war – in both military and veterans' hospitals – women who served, soldiers of color, and those with less visible injuries, (tuberculosis and shell-shock, for example), often faced even larger hurdles than others in their quest to access high-quality medical care. And within less than 15 years of the establishment of the Veterans' Bureau, costly veterans' benefits (for all ex-service

members) faced major cuts; indeed, the system remained vulnerable to being under-funded sporadically for the remainder of the twentieth century.

A variety of pertinent literature fields – from the history of military medicine to the role of interest groups in American politics – will be reviewed in the relevant chapters. Here, I discuss three areas of historical inquiry to which this dissertation contributes: soldiers’ and veterans’ benefits, the American welfare state, and public health policy.

### *A long history of veterans’ benefits*

The World War I era serves as only one chapter in a much longer story about a unique relationship between former service members and their government, however it also marks an important turning point. After the Revolutionary War, veterans received hard-fought pension payments in return for their service. Theda Skocpol’s formative work on citizenship rights and Civil War veterans notes that by the late 1880s, a colonial-era state-by-state system of veterans’ benefits had been largely replaced by a federal system, and a huge number of former service members, widows, and dependents across the nation – including more than one-third of all elderly men living in the North – received quarterly payments from the U.S. Pension Bureau.<sup>11</sup> In the late nineteenth century, veterans also won access to a national system of Soldiers’ Homes, which served mainly as domicile units for aged men with nowhere else to turn.<sup>12</sup>

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<sup>11</sup> Theda Skocpol, *Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States* (Cambridge, Mass.: Belknap Press of Harvard University Press, 1992), The data on the Pension Bureau is on p. 1.

<sup>12</sup> Even though some Soldiers’ Home campuses contained hospitals, the institutions were designed to serve – as their names suggested – as homes, rather than as medical care facilities. As this dissertation shows, that had much to do with the fact that hospitals were much maligned in the post-Civil War years, (whereas by World War I, they were more widely viewed as ideal venues for medical treatment). The formative work on Soldiers’ Homes is Patrick J. Kelly, *Creating a National Home: Building the Veterans’ Welfare State, 1860-1900* (Cambridge, Mass.: Harvard University, 1997). Soldiers’ Homes and other helpful secondary sources are discussed throughout this dissertation; see especially Chapters One and Four.

But the establishment of the Veterans' Bureau and veterans' hospitals – as many legislators of the time were only too eager to point out – went well beyond the measures of the past. Legislation of the early 1920s led not only to the outlay of millions of dollars for the benefit of millions of veterans, but it also firmly established an exclusive, publicly sponsored medical system that provided many former members of the military with a direct, personal, long-term, service- and institution-oriented connection with their government. In short, it was the bureaucratic fallout, activism, and legislation of the World War I era – not the pension system of the nineteenth century – that directly shaped veterans' benefits through the beginning of the twenty-first century.

Scholars who focus on the development of the veterans' welfare state in the 1930s and 1940s have recently pointed to the post-World War I era as crucial in shaping benefits moving forward. As Glenn C. Altschuler and Stuart M. Blumin put it, "it was clear even before the armistice of 1918 that postwar policymaking would never again be the same. Indeed, the innovations of the interwar period form an immediate and influential background to the proposals that would find their way into the G.I. Bill in 1944."<sup>13</sup> Likewise, Kathleen J. Frydl notes that "the political stewards who orchestrated (the GI Bill) were veterans of World War I; in some more informal way, they were also veterans of that poorly handled readjustment. The latter experience yielded some useful political knowledge."<sup>14</sup> Stephen Ortiz echoes that sentiment,

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<sup>13</sup> Glenn C. Altschuler; Stuart M. Blumin, *The G.I. Bill: A New Deal for Veterans* (New York, New York: Oxford University Press, 2009), 32.

<sup>14</sup> Kathleen J. Frydl, *The G.I. Bill* (New York, New York: Cambridge University Press, 2009), 37.

noting that in the wake of the Great War, “the federal government succeeded in setting up a seemingly judicious and incorruptible new veterans’ system,” which would be built upon later.<sup>15</sup>

The drastic change that took place in the nature of veterans’ benefits – and the enthusiastic fight for hospitals that was part and parcel of that change – was due in no small part to the dynamic state of American medicine and health care. In the first two decades of the twentieth century, thanks to advocacy efforts of professionals in the field, industrialization, and urbanization, the perception of health and hospitals was in transition. The germ theory of disease absolved individuals of blame for their ailments, and took away the shame of seeking care; illnesses like tuberculosis were gradually seen largely as products of one’s environment, as opposed to a form of punishment for individual moral transgressions. In the first decades of the twentieth century, chronic illnesses overtook epidemics as the leading cause of death among Americans, and gained credence as medical ailments best treated by professionals. At the same time, Progressives fought for state and federal assistance for workers who fell ill or sustained injuries on the job.<sup>16</sup> As these drastic changes occurred, doctors and administrators self-consciously ensured that hospitals boasted new technologies such as X-ray machines and amenities including well-appointed private rooms. By the second decade of the twentieth century, middle- and upper-class Americans were increasingly drawn to seeking medical care at such institutions, as opposed to in their homes. Medical care, in other words, was gradually professionalized and commodified.<sup>17</sup> In this historical context, services previously available to

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<sup>15</sup> Stephen R. Ortiz, *Beyond the Bonus March and G.I. Bill* (New York, New York: New York University Press, 2010), 16.

<sup>16</sup> *Dying for Work: Workers' Safety and Health in Twentieth-Century America* ed. David Rosner and Gerald Markowitz (Bloomington: Indiana University Press, 1989), See especially the introduction.

<sup>17</sup> The history (and historiography) of American hospitals will be discussed at length in Chapter One of this dissertation. For background: David Rosner, *A Once Charitable Enterprise* (Cambridge: Cambridge University Press, 1982). Charles E. Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (New York:

veterans – the convalescent care offered in Soldiers’ Homes a primary example – were rendered inadequate in the eyes of many.

A veterans’ hospital system also became a reality because of two unique characteristics of World War I. First, the medical ailments that resulted from the war lent themselves to treatment in newly idealized hospital settings. With the advent of more lethal weapons and improvements in military medicine, soldiers were more likely to sustain and survive dire injuries. More common than battlefield injuries were tuberculosis and various psychological conditions – chronic diseases that were widely believed to necessitate extended medical, as opposed to domicile or community-based, care. Second, the U.S. government instituted large-scale conscription to build up its army in 1917 and 1918. The state’s responsibility to draftees, it seemed to the general public and veterans themselves, was greater than it had been to career soldiers in other conflicts.<sup>18</sup>

### *The American welfare state*

Soldiers’ and veterans’ benefits are part of the larger American welfare state, which has been characterized by scholars as an amorphous mix between government and private interventions that assist the needy and various select members of society.<sup>19</sup> William J. Novak and

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Basic Books, 1987). Morris J. Vogel, *The Invention of the Modern Hospital: Boston, 1870-1930* (Chicago: University of Chicago Press, 1980). Rosemary A. Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (New York: Basic Books, 1989).

<sup>18</sup> Jennifer Keene touches on this idea: Jennifer D. Keene, *Doughboys, the Great War, and the Remaking of America* (Baltimore: The Johns Hopkins University Press, 2001).

<sup>19</sup> Linda Gordon points out that in the second half of the twentieth century, the term ‘welfare’ took on a negative connotation, as it was associated mainly with “debasement conditions of receiving public assistance...” She argues that while government programs intended mainly to assist poor people and people of color have been termed “welfare,” programs originally intended to benefit white males – Social Security, home mortgage tax deductions, and corporate subsidies, for example – have been called “entitlements.” In this framework, medical care for soldiers and veterans might traditionally be referred to as an “entitlement.” Paying heed to Gordon’s points, I use the terms “entitlement”

Gary Gerstle's recent debate about whether the American welfare state is strong or weak illuminates some key areas of concern for historians of social policy. Novak argues that the American state "is and always has been more powerful, capacious, tenacious, interventionist, and redistributive than was recognized in earlier accounts of U.S. history." He points out that the reach of the American state remains largely hidden because "it is so widely distributed among an exceedingly complex welter of institutions, jurisdictions, branches, offices, programs, rules, customs, laws, and regulations." Therefore, he says, "realistic and pragmatic approaches to American state development" must pay heed to the idea that "American power has long been distributed among a series of individuals, groups, parties, associations, organizations, and institutions not readily designated as wholly wither public or private."<sup>20</sup>

Gerstle, on the other hand, takes issue with the idea of "advancing an argument for (the) state's unremitting strength as a substitute for the older argument about its chronic weakness." The nature – and largesse – of the state, he argues, is a product of historical circumstance and, in the United States, it has changed considerably over time. Gerstle also notes that individual states have often "frustrated the legislative ambitions of the central state." Finally, he argues, Novak's characterization of the American welfare state's "public-private character" as a marker of strength overlooks "the way in which it enabled private interests to use public power for their own purposes."<sup>21</sup>

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and "welfare" interchangeably, defining both broadly as any and all "government contributions to citizens' well-being." Linda Gordon, *Pitied but Not Entitled: Single Mothers and the History of Welfare 1890-1935* (Cambridge, Massachusetts: Harvard University Press, 1998). This dissertation will show that soldiers and veterans of color fought for entitlements alongside their white counterparts, but they were often shunned from mainstream veterans' advocacy efforts and initially had only limited access to the martial welfare state.

<sup>20</sup> William J. Novak, "The Myth of The "Weak" American State," *The American Historical Review*, no. 113 (2008).

<sup>21</sup> Gary Gerstle, "A State Both Strong and Weak," *Ibid.* Vol. 115, no. No. 3 (June 2010).



In fact, attempting to come to a resolution about the question at the core of the Novak-Gerstle debate – whether one might characterize the American welfare state as strong or weak – is less productive than addressing the question of how and why the American welfare state developed, over time, as it did. After all, both scholars (and many others) agree that the structure of the U.S. state is highly complex, disbursed, and decentralized.

Historians have provided various explanations for the shape of the American welfare state. According to Ira Katznelson and Alice Kessler-Harris, for example, federal social programs such as Social Security were guided largely by ideology, and strongly entrenched notions that white males were the only citizens worthy of so-called entitlements. The most generous social programs, Kessler-Harris and Katznelson have shown, reinforced societal racial and gender hierarchies, in that they were initially largely inaccessible to white women and all African Americans.<sup>22</sup> Linda Gordon also argues that welfare programs entrenched, rather than unsettled societal norms. So-called pension and aid programs designed for the benefit of impoverished mothers in the 1920s and 1930s, Gordon shows, were intended to protect women who had been shut out of the one acceptable model of household economy: reliance on a male breadwinner. The resulting mothers' pensions programs were under-funded and demeaning.<sup>23</sup> In the inter-war years, Katznelson, Kessler-Harris, and Gordon all show, policy-makers based social programs on the idea that there were deserving and undeserving poor people.

Historian Jennifer Klein and political scientist Jacob S. Hacker make arguments more centered on institutional development. Privately-funded initiatives, both scholars argue, have

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<sup>22</sup> Alice Kessler-Harris, *In Pursuit of Equity: Women, Men and the Quest for Economic Citizenship in Twentieth Century America* (Oxford, England: Oxford University Press, 2001). Ira Katznelson, *When Affirmative Action Was White: An Untold History of Racial Inequality* (New York, New York and London, England: W.W. Norton & Company Ltd., 2005).

<sup>23</sup> Gordon, *Pitied but Not Entitled: Single Mothers and the History of Welfare 1890-1935*.

undercut the expansion of a more extensive public welfare system. Klein reaches back to the first decades of the twentieth century, describing the rise of employer- and union-sponsored health plans through a telling profile of the increasing powers and capabilities of the insurance industry. By the New Deal years, she argues, the boundaries of the American national welfare system – which remain largely intact to this day – were formally set: the private programs of the 1910s and 1920s would provide benefits alongside public ones, forming a cooperative arrangement between business and government.<sup>24</sup>

While Klein discusses the American welfare state and, more specifically, health benefits, in the context of welfare capitalism and an ongoing ideological and power struggle between employers, unions, and a variety of other interest groups, Jacob Hacker uses a different framework. Like Klein, he emphasizes the idea that public and private benefits historically have been “path dependent”; the development of one has reinforced the development of the other. (The fact that Medicare covers only the elderly, for example, was path dependent on the fact that employer-sponsored benefits had been developed to cover workers.) But Hacker draws on different evidence to make his case. Instead of examining American industry and the players surrounding it, he investigates the political structures behind the development of the American “welfare regime.” This regime, Hacker says, consists of three elements: several direct-spending programs – for example, Medicare, Medicaid and Social Security; “indirect or hidden government interventions,” including tax breaks, regulations and credit subsidies; and finally,

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<sup>24</sup> Jennifer Klein, *For All These Rights: Business, Labor, and the Shaping of America's Public-Private Welfare State* (Princeton, New Jersey: Princeton University Press, 2003). For another interpretation of the origins of employer-based insurance, see John E. Murray, *Origins of American Health Insurance: A History of Industrial Sickness Funds* (New Haven, Connecticut: Yale University Press, 2007).

private social protections, a product of both “government policy and of the distinctive organizational and economic imperatives of the institutions that provide them.”<sup>25</sup>

Military and veterans’ medical care in the World War I era showcases the “characteristic sprawl” of the American state, but it is also an example of strong state centralization.<sup>26</sup> During and after the war, the army and federal government allowed private organizations, such as the American Red Cross and the American Legion, to play a large role in defining and executing policies pertaining to the nature and extent of hospital care for soldiers and veterans. But the later creation of the Veterans’ Bureau and the veterans’ hospital system serves as a distinctive example of the U.S. government declining to relegate welfare to the private sector, and instead, creating a massive federal bureaucracy. Indeed, from the 1920s on, veterans’ medical care has remained a foundational direct spending program.

The story of soldiers’ and veterans’ medical care in the World War I era corresponds with histories of other welfare programs, which were governed by strongly entrenched ideals regarding race, class, and gender. Although veterans’ hospitals were accessible to white women and people of color, they were by no means egalitarian; policymakers designed the system holding the interests of white, male veterans as their highest priority. In this way, Veterans’ Bureau hospitals left intact an important precedent for the federal welfare programs that followed.

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<sup>25</sup> Jacob S. Hacker, *The Divided Welfare State: The Battle over Public and Private Social Benefits in the United States* (Cambridge, England: Cambridge University Press, 2002). For an earlier treatment of related issues, see Odin W. Anderson, *The Uneasy Equilibrium: Private and Public Financing of Health Services in the United States, 1875-1965* (New Haven, Connecticut: Yale University Press, 1968).

<sup>26</sup> The quote is from Novak, "The Myth of The "Weak" American State," 766.

## Public health and health policy

This study of military and veterans' health care in World War I fits into a larger field of public health history defined as "the history of collective action in relation to the health of populations."<sup>27</sup> It is guided by the calls of public health historians who came of age in the 1970s (as part of a larger generational movement taking place in many academic fields), and who argued that the history of medicine and public health should go beyond the study of "great doctors." Social history and circumstance, these scholars said, are highly relevant to larger stories about medicine and health.<sup>28</sup> Over the past forty years, following that historiographical tide change, scholars have pursued important work on the effects of epidemic and chronic diseases on immigrant and minority populations.<sup>29</sup> Like previous studies, this dissertation notes the importance of social factors in shaping not only the experience of disease, but also how a society elects to respond to a perceived health need.

Recently, as debates about the state of the American health care system have garnered public and political attention, medical and public health historians have put out a new call for the relevance of history to the study of health policy. More than twenty years ago, Robert Kelley argued that historians must endeavor to study the history of public policy, just as they study areas

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<sup>27</sup> Dorothy Porter, "The History of Public Health: Current Themes and Approaches," *Hygeia Internationalis, An Interdisciplinary Journal for the History of Public Health* 1(1999): 13.

<sup>28</sup> Susan Reverby; David Rosner, "Beyond 'the Great Doctors'," in *Health Care in America: Essays in Social History*, ed. Susan Reverby; David Rosner (Philadelphia, Pennsylvania: Temple University Press, 1979). For a follow-up from Reverby and Rosner, see ———, "'Beyond the Great Doctors' Revisited," in *Locating Medical History: Stories and Their Meanings*, ed. Frank Huisman; John Harley Warner (Baltimore, Maryland: The Johns Hopkins University Press, 2004).

<sup>29</sup> See, among many others, Howard Markel, *Quarantine!: East European Jewish Immigrants and the New York City Epidemics of 1892* (Baltimore, Maryland: The Johns Hopkins University Press, 1999). Judith Walzer Leavitt, *Typhoid Mary: Captive to the Public's Health* (Boston, Massachusetts: Beacon Press, 1996). Jr. Samuel Kelton Roberts, *Infectious Fear: Politics, Disease, and the Health Effects of Segregation* Studies in Social Medicine (Chapel Hill, North Carolina: The University of North Carolina Press, 2009). Keith Wailoo, *Dying in the City of the Blues: Sickle Cell Anemia and the Politics of Race and Health* (Chapel Hill, North Carolina: The University of North Carolina Press, 2000).

such as the family and immigration. By “making historical studies of what happened to adopted policies once they were put into operation,” Kelley said, “historians can make an especially important contribution.”<sup>30</sup> More recently, Charles Rosenberg has noted that studying the history of health policies, in particular, “tells us a great deal about the relationships among interest and ideology, formal structures and human need, professionalization and social welfare, and technology and its applications.”<sup>31</sup> Rosenberg, among others, argues not only for the relevance of history but also for the necessity of defining health policy broadly. That term, argues Rosemary A. Stevens, denotes more than just pieces of legislation. Health policies “reflect more general perceptions about what is important or fair or doable (or all three) in a particular culture, at a particular time, in a particular place.”<sup>32</sup> To these ends, this dissertation looks at conditions and policy debates surrounding soldiers’ and veterans’ hospital care in an effort to illuminate larger realities about changing perceptions of health, medicine, governmental responsibility, and citizenship rights in World War I era America.

In the small but growing literature field of the history of U.S. health policy, one question (related to the topic of this dissertation) reigns supreme: Why did the United States remain,

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<sup>30</sup> Robert Kelley, “The History of Public Policy: Does It Have a Distinctive Character and Method,” in *Federal Social Policy: The Historical Dimension*, ed. Donald T. Critchlow and Ellis W. Hawley (University Park, Pennsylvania: Pennsylvania State University Press, 1988).

<sup>31</sup> Charles E. Rosenberg, *Our Present Complaint: American Medicine, Then and Now* (Baltimore, Maryland: The Johns Hopkins University Press, 2007), 186.

<sup>32</sup> Rosemary A. Stevens, “Introduction,” in *Putting the Past Back In: History and Health Policy in the United States*, ed. Rosemary A. Stevens; Charles E. Rosenberg; Lawton R. Burns (New Brunswick, New Jersey: Rutgers University Press, 2006), 2. Two political scientists offer an expansive and apropos definition of health policy as encompassing everything from “who is and is not eligible to receive subsidized care” and “what nurses can and cannot do for patients” to “how wide the doorways of hospital bathrooms should be” and “how federal tax policy and workers’ protection laws interact with various health care laws.” Carol S. Weissert; William G. Weissert, *Governing Health: The Politics of Health Policy, Third Edition* (Baltimore, Maryland: Johns Hopkins University Press, 2006), 304. William Shonick takes a similarly broad view of federal involvement in health care. William Shonick, *Government and Health Services: Government's Role in the Development of U.S. Health Services, 1930-1980* (New York, New York: Oxford University Press, 1995).

throughout the twentieth century, the only wealthy nation with no system of nationally sponsored health insurance?<sup>33</sup> Historian Colin Gordon identifies six key historical moments in the national health insurance policy debate, each ending in defeat for proponents of a state sponsored system of universal coverage. Between 1910 and 1933, Progressives centered their efforts on the American Association for Labor Legislation, which lobbied for state-by-state government-sponsored insurance, and in the mid-1930s, there was support for the inclusion of national health insurance in the Social Security Act of the New Deal. In both instances, concerns about “socialism” put forth by interest groups including the American Medical Association drowned out calls for equal access. Between 1945 and 1950, the idea for national health insurance surfaced again, but was countered by alternatives focused on enhancing what was, by then, a well-established private, employer-based system of benefits. In the 1950s and 1960s, as some held tight to the notion of universal insurance, moderates and conservatives focused on the politically safer task of filling in the gaps of private insurance – providing coverage for the needy and elderly – eventually leading to the 1965 passage of Medicare and Medicaid. In the 1970s, as costs of care rose, president Richard Nixon proposed the Comprehensive Health Insurance Plan, which stipulated that firms with more than 25 employees provide employer-sponsored coverage for workers and their families. Nixon’s plan, which also included programs that would improve

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<sup>33</sup> Numerous health policy articles and books (some of which are discussed herein) are motivated by this question, though they may not take it as their primary focal point. Examples of books focused specifically on the struggle for government sponsored health insurance in the U.S. include: Paul Starr, *Remedy and Reaction: The Peculiar American Struggle over Health Care Reform* (New Haven, Connecticut; London: Yale University Press, 2011). Alan Derickson, *Health Security for All: Dreams of Universal Health Care in America* (Baltimore, Maryland: Johns Hopkins University Press, 2005). Philip J. Funigiello, *Chronic Politics: Health Care Security from F.D.R. To George W. Bush* (Lawrence, Kansas: University Press of Kansas, 2005). Beatrix Hoffman, *The Wages of Sickness: The Politics of Health Insurance in Progressive America* (Chapel Hill and London: The University of North Carolina Press, 2001). Ronald L. Numbers, *Compulsory Health Insurance: The Continuing American Debate* (Westport, Connecticut: Greenwood Press, 1982). Daniel S. Hirshfield, *The Lost Reform: The Campaign for Compulsory Health Insurance in the United States from 1932-1943* (Cambridge, Massachusetts: Harvard University Press, 1970).

and take the place of both Medicaid and Medicare, died in the wake of his 1974 resignation from office. By the early 1990s, the final key moment identified by Gordon, the Clinton health plan had abandoned efforts at government-sponsored universal health insurance, instead calling for federal subsidies, and a blanket enhancement of the private employer-based system. At any one of these moments, a combination of forces – war, the politics of the election cycle, and a conflagration of private interests – shaped debates, and, in turn, the piecemeal policies (Medicare and Medicaid, for example) that eventually surfaced. As a result, at the beginning of the 21<sup>st</sup> century, the American system of health insurance rested precariously on a divided foundation of publicly- and privately-administered benefits.

The Veterans' Bureau and its hospitals are a great anomaly when one considers their political context. They were established in the early 1920s, in the shadow of the Great War, when a conservative Congress and a new Republican president demonstrated great eagerness to prioritize fiscal discipline. In fact, the traditional historical narrative paints the 1920s mostly as a dark and static moment in the allocation of government entitlements, after the disbursal of benefits for Civil War veterans in the nineteenth century, and before the watershed measures of the New Deal in the 1930s. For example, Colin Gordon writes: "Beyond Sheppard-Towner, the 1920s saw no significant health reform proposals... Republican administrations pressed voluntarist solutions through organizations like the American Child Health Association."<sup>35</sup> But in

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<sup>34</sup> Colin Gordon, *Dead on Arrival: The Politics of Health Care in Twentieth Century. America* (Princeton, New Jersey: Princeton University Press, 2003), 12-45.

<sup>35</sup> Ibid., 14. Some scholars of American health policy overlook the importance – or, even existence – of a national system of veterans' medical care. Carol S. Weissert and William G. Weissert call Medicare, which was passed in 1965, "the first major federal health program guaranteeing health care for a large targeted population." Weissert, *Governing Health: The Politics of Health Policy, Third Edition*, 314. The work of Rosemary Stevens, to be discussed later in this introduction, serves as a notable exception: Rosemary A. Stevens, "Can the Government Govern? Lessons from the Formation of the Veterans Administration," *Journal of Health Politics, Policy and Law* Vol. 16, no. No. 2 (1991). ———, "The Invention, Stumbling, and Re-Invention of the Modern U.S. Veterans

spite of efforts by legislators in the 1920s to ensure that the Veterans' Bureau would be only a temporary fix to a short-lived problem, it became a crucial federal agency. It was the forerunner to the current United States Department of Veterans Affairs, which oversees the Veterans Health Administration (VHA) – “the largest integrated health care system in the United States.”<sup>36</sup> The VHA serves approximately 8.3 million beneficiaries, who have access to a variety of types of institutions, including more than 150 hospitals.<sup>37</sup>

Even as scholars of American health policy eschew a focus on the formative nature of the early years of the Veterans' Bureau, they acknowledge the agency's overall importance within the American welfare state. In addition to providing direct assistance to a large swath of citizens, they say, it created one sector of a “protected public” who would thereafter be likely to oppose health care reform for the larger population.<sup>38</sup>

Such a phenomenon was uniquely American. In other Western nations, World War I helped instantiate a faith in professional medicine, but instead of bringing about a long-term medical system for one sector of the population, it served as a catalyst for ongoing movements toward the nationalization of health programs. In England, for example, doctors who had served in the war became advocates for “reorganizing medical services at home” so they could be more

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Health Care System, 1918-1924,” in *Veterans Policy, Veterans Politics: New Perspectives on Veterans in the Modern United States*, ed. Stephen R. Ortiz (Gainesville: University Press of Florida, forthcoming).

<sup>36</sup> Adam Oliver, “The Veterans Health Administration: An American Success Story?,” *The Milbank Quarterly* Vol. 85, no. No. 1 (2007).

<sup>37</sup> In 2011, the VA had a budget of more than \$120 billion in order to administer services to its potential claimants – more than 22 million former service members and their dependents. “Department of Veterans Affairs Statistics at a Glance,” <http://www.va.gov/vetdata/docs/quickfacts/Homepage-slideshow.pdf>.

<sup>38</sup> The phrase “protected public” is from Starr, *Remedy and Reaction: The Peculiar American Struggle over Health Care Reform*, Introduction. Also see: Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982), 283, 89. Gordon, *Dead on Arrival: The Politics of Health Care in Twentieth Century. America*, 133.



coordinated and accessible for the greater population.<sup>39</sup> There, the notion that a great portion of those eligible to serve in the military were unable due to lack of physical fitness, argues Harry Eckstein, “drove home the fact that the general public has a large stake in the health” of potential fighters.<sup>40</sup> Many had come to the same conclusions in the U.S., but failed to convince the larger public that it indicated the necessity for a large-scale change in access to medical services. In England, the realization helped bring about the 1919 creation of the office of the Ministry of Health and a series of laws throughout the 1920s aimed at a “reorganization of medical care in the best interests of the general public.”<sup>41</sup> The policies of the interwar years helped the country transition from the 1911 National Health Insurance Bill, which served as a compulsory workers’ insurance system, to the 1948 establishment of the National Health Service, which offered free medical care to the entire population.<sup>42</sup> England, like France, Germany, and Canada, initially offered special medical and rehabilitation services to soldiers and veterans in the World War I years, but instead of dovetailing off into permanent specialized medical systems, the programs were eventually largely subsumed by or integrated into larger national health structures.<sup>43</sup>

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<sup>39</sup> The quote is from Daniel M. Fox, *Health Policies, Health Politics* (Princeton: Princeton University Press, 1986), 26-36.

<sup>40</sup> Harry Eckstein, *The English Health Service: Its Origins, Structure, and Achievements* (Cambridge, Massachusetts: Harvard University Press, 1950), 84-87.

<sup>41</sup> Although the ideal of improved access was more widely accepted by virtue of the country’s experiences in World War I, a centralized system based on “hierarchical regionalism” faced many challenges in its early years. Fox, *Health Policies, Health Politics*, 85-86.

<sup>42</sup> Rudolf Klein, *The Politics of the National Health Service* (London; New York, New York: Longman, 1983), 1-10. On Britain’s treatment of the war-wounded, see Joanna Bourke, *Dismembering the Male: Men's Bodies, Britain, and the Great War* (Chicago: University of Chicago Press, 1996).

<sup>43</sup> On the development of the French welfare state, see Paul V. Dutton, *Origins of the French Welfare State*, New Studies in European History (Cambridge: Cambridge University Press, 2002). Also, B. Jean de Kervasdoué; Christine Meyer; Caroline Weill; Agnes S. Couffinal, “French Health Care System: Inconsistent Regulation,” in *Health Policy Reform: National Variations and Globalization*, ed. Christa Altenstetter; James Warner Bjorkman (New York, New York: St. Martin's Press, 1997). On France’s treatment of the war-wounded, see Roxanne Panchasi, “Reconstructions: Prosthetics and the Rehabilitation of the Male Body in World War I France,”

The health benefits extended to U.S. soldiers and veterans during the World War I period tell us much about the development of American social and health policy. In many respects, the eventual establishment of a national system of veterans' hospitals indicated a massive expansion of the reach of government: they provided an institutional safety net for one group of citizens, and went a long way in ensuring the well-being of generations of veterans who made great personal sacrifices. The implementation of a veterans' hospital system also illustrates the tendency of the United States government to award entitlements selectively, to those who advocate strongly for themselves by demonstrating worthiness as well as need. Given these factors, legislation of the 1920s pertaining to soldiers' and veterans' hospital care deserves to be considered – alongside later federal assistance programs such as Social Security and Medicare – as foundational in the development and shape of the American welfare state and health policy.

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*Differences: A Journal of Feminist Cultural Studies* 7, no. 3 (1991). On the German welfare state, see Duane A. Matcha, *Health Care Systems of the Developed World: How the United States Remains an Outlier* (Westport, Connecticut; London: Praeger, 2003), 99-125. E.P. Hennock, *The Origin of the Welfare State in England and Germany, 1850-1914: Social Policies Compared* (Cambridge: Cambridge University Press, 2007). Also, David F. Crew, *Germans on Welfare: From Weimar to Hitler* (Oxford; New York, New York: Oxford University Press, 1998). On Germany's treatment of the war-wounded, see: Robert Weldon Whalen, *Bitter Wounds: German Victims of the Great War, 1914-1939* (Ithaca, New York; London: Cornell University Press, 1984). For an especially interesting analysis of the treatment of German and British veterans following the World War, see Deborah Cohen, *The War Come Home: Disabled Veterans in Britain and Germany, 1914-1939* (Berkeley and Los Angeles, California: University of California Press). Cohen makes the counter-intuitive argument that the German state-centered system led to resentment and a feeling of isolation among former soldiers, whereas the British voluntarist one made them feel welcomed and embraced. On the Canadian welfare state, see Jacqueline S. Ismael, *The Canadian Welfare State: Evolution and Transition* (Alberta: University of Alberta Press, 1987). On Canada's World War I era medical and rehabilitation program for soldiers and veterans, see Desmond Morton, "Military Medicine and State Medicine: Historical Notes on the Canadian Army Medical Corps in the First World War, 1914-1919," in *Canadian Health Care and the State: A Century of Evolution*, ed. C. David Naylor (Montreal and Kingston; London; Buffalo, New York: McGill-Queen's University Press, 1992). Mary Tremblay offers a bit of perspective on Canadian rehabilitation policy in the interwar years: Mary Tremblay, "Lieutenant John Counsell and the Development of Medical Rehabilitation and Disability Policy in Canada," in *Disabled Veterans in History*, ed. David A. Gerber (Ann Arbor, Michigan: University of Michigan, 2012). David Gerber's volume is trans-national in focus and offers a useful overview of some of the central issues of concern regarding disabled veterans throughout history: David A. Gerber, *Disabled Veterans in History* (Ann Arbor, Michigan: University of Michigan, 2012). For a concise source on the development of public health in a variety of nations, see Dorothy Porter, *The History of Public Health and the Modern State* (Amsterdam; Atlanta, Georgia: Rodopi, B.V., 1994).

Studies on World War I era medical care and social policy

Rosemary A. Stevens asks a question of particular relevance to this dissertation: “How does a country without a national health program for all justify national health benefits for a few?” The success of federal health programs in the U.S. – the funding of biomedical research, medical care for the elderly and poor, and hospital care for veterans – “rests on the ability to define a group clearly as a distinct and limited class of beneficiaries,” Stevens concludes. Furthermore, she argues, U.S. health policy is “not a product of political philosophy but a response to sectional or immediate needs, a crisis of the moment, rather than any long-term social agenda.” Stevens studies the establishment of the veterans’ medical system in order to ascertain whether the U.S. government could successfully administer a health program. And, she concludes, the “veterans’ case is a good example of American flexibility in policy-making... the system worked!”<sup>44</sup> In a later book chapter about the establishment of the Veterans’ Administration, Stevens provides a rich picture of how and why the Veterans’ Bureau came to be, arguing that two major forces led to the creation of a veterans’ hospital system: a vocal veterans’ lobby that drew attention to the problems at hand, and an increasing drive to “reform federal government agencies under the banner of business efficiency.”<sup>45</sup>

Stevens’ accounts are the most recent and thorough of a handful of book chapters, scholarly articles, and congressional reports examining the advent of a veterans’ medical system in the World War I years. Robert D. Leigh, Gustavas A. Weber, and William P. Dillingham provide earlier overviews of the core issues that arose in relation to veterans’ medical care in the

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<sup>44</sup> Stevens, "Can the Government Govern? Lessons from the Formation of the Veterans Administration," 302, 282-85.

<sup>45</sup> ———, "The Invention, Stumbling, and Re-Invention of the Modern U.S. Veterans Health Care System, 1918-1924."

World War I era.<sup>46</sup> Their accounts serve as accessible and utilitarian guides to the major turning points and most important pieces of legislation of the period. They mention some of the primary players involved, and key areas of conflict. On the whole, these scholars are most interested in what went wrong in the arena of soldiers' and veterans' medical care, the role played by the federal government during a turbulent time, and who was to blame for shortfalls in the system. Robert D. Leigh, for example, writing less than a decade after the Armistice – as “furnishing national medical and hospital service on a huge scale” continued to pose a problem – argues that in the story of post-war care for soldier and veterans, “Bureau experts are the heroes and the Congressmen the villains.”<sup>47</sup>

My project is aimed at providing both detail and context for the events and conflicts explored briefly in these works, and presenting new questions and points for consideration: Why did the army initially become the entity that would oversee rehabilitation? What did army rehabilitation look like, and how did it help pave the way for demands for further care? How did soldier- and veteran-patients perceive the care they were receiving? What was the nature of the transition from military to civilian care, and why was there so much tension between agency authorities in the post-war years? How and why did veterans' groups become involved in the battle for veterans' hospitals, and what was the impact of their efforts? On a more general level: What does soldiers' and veterans' medical care in the World War I era reflect about military and

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<sup>46</sup> Leigh, *Federal Health Administration in the United States*. Also see: William Pyrlle Dillingham, *Federal Aid to Veterans, 1917-1941* (Gainesville, Florida: University of Florida Press, 1952). Gustavus Adolphus Weber and Laurence Frederick Schmeckebier, *The Veterans' Administration, Its History, Activities and Organization* (Washington, D.C.: Brookings Institution, 1934). R.E. Adkins, *Medical Care of Veterans*, Printed for the House Committee on Veterans Affairs Ninetieth Congress, First Session, (Washington, DC: Government Printing Office, April 1967). For an overview of the pre-World War I period, see William H. Glasson, *Federal Military Pensions in the United States* (New York: Oxford University Press, American Branch, 1918).

<sup>47</sup> Leigh, *Federal Health Administration in the United States* 214.

veterans' policy in the twentieth century? What does it reveal about values surrounding public health and medicine in the United States? What does it tell us about the American welfare state?

In my story, there is no hero or villain; there is mass confusion and disagreement about how to plan for (and eventually fulfill) an unknown need, about bureaucratic jurisdiction, and about what was logical and rational for a government to provide for a group of citizens. In order for a health crisis to get attention, I argue, it has to fit a prevailing social agenda. And only when people can "apply their values" to potential solutions do they become acceptable.<sup>48</sup> As this dissertation aims to make clear, such was the case for veterans' hospital care following World War I.

A handful of book-length projects exist relating to the general topic of World War I era health care for U.S. soldiers and veterans. Recent work especially pertinent to this dissertation focuses on connections between the army rehabilitation program and changing notions of disability, the treatment of specific diseases by the Army Medical Department, and the impact of the period's social policies on the American welfare state.

Beth Linker's work on rehabilitation in the World War I era shows that the period marked a turning point in the understanding of disability in the United States, one in which rehabilitation – as opposed to the provision of pensions – became a governmental and military priority.<sup>49</sup> Linker's conclusions have important implications for a study of the roots of the veterans' medical system: they help demonstrate why hospitals, and the prospect of "cure" that they represented, became a central focus of World War I era policies. While Linker uses military

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<sup>48</sup> The term is from Starr, *Remedy and Reaction: The Peculiar American Struggle over Health Care Reform*, 9.

<sup>49</sup> Beth Linker, "For Life and Limb: The Reconstruction of a Nation and Its Disabled Soldiers in World War I America" (PhD, Yale University, 2006). ———, *War's Waste: Rehabilitation in World War I America* (Chicago, Illinois: University of Chicago Press, 2011).

health initiatives in order to elucidate changing understandings of disability, I use them instead as a means of examining broad questions about health policy and the American welfare state. Linker looks at how army rehabilitation efforts came about, and what a new emphasis on rehabilitation said about core societal values, including manhood and work.<sup>50</sup> I investigate how and why the army rehabilitation program was at once comprehensive and vague, where related efforts of multiple government agencies ultimately fell short, and how hospital care came to be battled over and won as a political right for some U.S. citizens.

Carol R. Byerly has also done much to improve our understanding of the larger implications of military health initiatives in the World War I period. Her books on the army's treatment of influenza and tuberculosis show that the medical fallout of war extends well beyond highly visible battlefield injuries such as gunshot wounds and amputations. In fact, according to Byerly, chronic illness and disease were hugely influential in shaping governmental and military medical efforts during and after the First World War.<sup>51</sup> This dissertation builds upon Byerly's findings, arguing that the veterans' hospital system came to be not mainly because there was a perceived necessity to care for a relatively small number of those who incurred visible wounds in battle, but in order to treat the long-term effects of chronic diseases such as tuberculosis and mental illnesses.

K. Walter Hickel's work focuses less directly on the health of soldiers than it does on the ideology of government-sponsored benefits for them, and the relationship of the latter to the

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<sup>50</sup> Linker, *War's Waste: Rehabilitation in World War I America*. An especially useful source on the history of perceptions of disability is Paul K. Longmore, *Why I Burned My Book and Other Essays on Disability* (Philadelphia: Temple University Press, 2003).

<sup>51</sup> Carol R. Byerly, *Fever of War: The Influenza Epidemic in the U.S. Army During World War I* (New York: New York University Press, 2005). ———, *Good Tuberculosis Men: The Army Medical Department's Struggle with Tuberculosis* (Washington, D.C.: Borden Institute, Forthcoming).

development of welfare in the United States. Hickel argues that the 1917 War Risk Insurance Act established three major principles on which the American welfare state came to rest: federally-sponsored allotments and allowances for the financial support of mothers who could not draw support from male providers; disability as a justification for support; and vocational training programs for the rehabilitation of those who lost the capacity for wage labor. According to Hickel, the Act “initiated modern social policy in the United States.” The WRIA is crucial to U.S. social policy history, he argues, because the privileges it offered to disabled soldiers were eventually “extended one by one to the civilian population throughout the country.”<sup>52</sup>

This study corroborates the finding that the WRIA helped normalize the idea of offering vocational rehabilitation to injured industrial workers, and substantiated the notion that disabled people and their dependents were worthy, as a group, of monetary and institutional benefits. But my interpretation of the significance of social policies passed during the World War I era differs from that of Hickel. One benefit guaranteed to veterans by the WRIA that was never extended to all Americans was access to government sponsored medical care. The granting of the latter to soldiers and veterans can, in fact, be seen as one of the first major policies that *limited* the reach of the institutional federal welfare state to a select few based on ideals of service and honor. The War Risk Insurance Act helped set the precedent that only some were worthy of access to publicly funded health benefits and put in place a framework for a distinctly selective American welfare state.

That crucial piece of legislation serves as the starting point of our story.

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<sup>52</sup> K. Walter Hickel, "Entitling Citizens: World War I, Progressivism, and the American Welfare State, 1917–1928" (Ph.D. Dissertation, Columbia University, 1999 ), 105-7. Also see ———, "'Justice and the Highest Kind of Equality Require Discrimination': Citizenship, Dependency, and Conscription in the South, 1917-1919," *Journal of Southern History* Vol. 66(November 2000).

## CHAPTER ONE

### **Preparing the homefront for the health outcomes of war: Policy provisions for domestic medical care of service members (1917)**

In the months surrounding the United States' declaration of war in April 1917, government officials and medical professionals readily acknowledged that wounded and ill soldiers were an inevitable consequence of raising a mass army. Practitioners and policy makers knew that thousands of troops and support personnel had been treated in England and France since 1914 for a variety of ailments, from psychological conditions and tuberculosis to amputations and gun shot wounds. Even so, the details of how to provide for the long-term health needs of veterans were pushed aside as seemingly more pressing issues – the legitimacy of U.S. entry in a European war, mobilizing the nation's economy for the conflict, the justness of military conscription – occupied public and congressional attention. Some policymakers, doctors, and government bureaucrats made it their business to call attention to the notion that soldiers would eventually become wounded and ill citizens in need of extended care, and attempted to plan accordingly. But their efforts were poorly coordinated and, in some cases, short-sighted, in part because the problem was both daunting and unpredictable in scope. Medical professionals and social reformers who shaped pre-war policies argued that major rehabilitation work should be overseen by the military. According to their rationale, by the time most soldiers were discharged as civilians, they would be fully medically rehabilitated and relatively self-reliant.

The War Risk Insurance Act (WRIA), records of the Council of National Defense (CND), and the army reconstruction plan showcase how social reformers, politicians, medical professionals, and military personnel envisioned soldiers' and veterans' medical care. Analyzed



together, they provide a rich picture of the means by which the U.S. government prepared for the health outcomes of the Great War; they demonstrate that early policy discussions and decisions honored much-prized Progressive Era ideals of industrial efficiency, but left important questions unanswered. The injustices that were perceived to result from somewhat haphazard pre-war planning provided the political capital necessary for advocates of veterans' rights to successfully lobby for a nationwide veterans' hospital system. Pre-war laws regarding soldiers' after-care, in other words, helped justify the claim that veterans were entitled to access to federally-funded hospitals.

### *The War Risk Insurance Act*

Amendments to the 1914 War Risk Insurance Act, debated during the summer of 1917 and approved October 6, 1917, set the legislative tone for the conceptualization of the treatment of Great War soldiers and veterans – wounded, ill, or healthy. The WRIA, which aimed first and foremost to provide life and disability insurance benefits to service members and their families, envisioned soldiers and veterans as potential economic and industrial liabilities. In this way, the legislation was representative of the larger realities of the period; concurrent Progressive efforts to promote employer-based insurance coverage, workers' compensation, and advances in industrial hygiene gained relevance by centering on the message that healthy workers were productive workers. Relatively good medical care (or at least *some* medical care), in other words, was good business. It was logical then, that the WRIA guaranteed that those who needed medical services could receive them courtesy of the federal government. The act stopped short, however, of stipulating where and how those services could be accessed. As one scholar has written: "The War Risk Act contained a promise of complete medical and hospital care, including prosthetic

appliances and other supplies, to be provided at government expense for veterans with service-connected disabilities; but no provision was made for implementing the promise.”<sup>1</sup>

Expanding on the War Insurance Law of 1914, which offered government sponsored insurance for American ships assisting in the war effort, and was later amended to include coverage for the captains and crews of those ships, the 1917 WRIA indicated that the U.S. had an expanded agenda when it came to ensuring security, not only for those who served, but for their families as well. As Walter Hickel has pointed out, the legislation, in many ways, was “intended to benefit families, not individual men.”<sup>2</sup> It guaranteed that the United States government would supplement compulsory monthly allotments paid by service members to their wives and children. The statute provided drafted soldiers the option of purchasing life insurance policies of \$1,000 to \$10,000 and, like the Civil War era General Pension Act, offered compensation for disability incurred in the line of duty. Unlike laws passed to benefit veterans of the Revolutionary and Civil Wars, however, the payments were based not only on need and whether or not a veteran was disabled, but also on how many family members he supported, the type of disability he incurred, and the extent to which it hindered his earning power. Those conditions eventually became onerous for caregivers and the government to measure.

In addition to providing payments to families and life and disability insurance, the War Risk Insurance Act guaranteed that those who needed medical care could receive it, but it did not stipulate where and how. According to Section 302 of the act, “the injured person shall be furnished by the United States such reasonable governmental medical, surgical, and hospital

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<sup>1</sup> William Pyrrle Dillingham, *Federal Aid to Veterans, 1917-1941* (Gainesville, Florida: University of Florida Press, 1952), 58.

<sup>2</sup> K. Walter Hickel, "Entitling Citizens: World War I, Progressivism, and the American Welfare State, 1917–1928" (Ph.D. Dissertation, Columbia University, 1999 ), 116-19.

services and with such supplies, including artificial limbs, trusses, and similar appliances, as the director (of the Bureau of War Risk Insurance) may determine to be useful and reasonably necessary...”<sup>3</sup> The law contained no further explanation of how such ideals would become reality. The oversight was glaring, considering that medical care was, at the time, viewed as an occasionally costly commodity. Extracts from a report to the Dallas Wage Commission of April 1917, for example, which were included in debates regarding the WRIA, noted that medical costs as well as “loss of time through... sickness” could represent “a double loss” for an employee.<sup>4</sup>

The War Risk Insurance Act was shaped by four major assumptions and ideas. Its authors aimed to discourage the dependency that was thought to have increased among Civil War veterans in the late nineteenth century. At the same time, they subscribed to the long-held belief that the national government had a responsibility to those who served in the military. Third, War Risk Insurance Act architects considered the composition of the World War I era American Expeditionary Forces, arguing that the federal government had a particularly heavy obligation to its soldiers, given that the majority had not volunteered, but instead were conscripted to serve. Finally, A.E.F. soldiers were envisioned as fathers, brothers, and sons – pillars of their families’ economic security – as opposed to individuals without obligations.

As they debated the contents of the War Risk Insurance Act in the summer of 1917, politicians, insurance experts, and social reformers openly acknowledged that the primary

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<sup>3</sup> An Act to Amend an Act Entitled 'an Act to Authorize the Establishment of a Bureau of War Risk Insurance in the Treasury Department,' Approved September Second, Nineteen Hundred and Fourteen, and for Other Purposes, Public Law 90, H.R. 5723, 40 Stat. 398, Sixty-Fifth Congress, First Session, (Washington, D.C.: Government Printing Office, October 6, 1917), 406.

<sup>4</sup> To Amend the Bureau of Insurance Act So as to Insure the Men in the Army and Navy, Hearings before the Committee on Interstate and Foreign Commerce, H.R. 5723, Part 3, Sixty-Fifth Congress, First Session, (Washington, D.C.: Government Printing Office, August 24, 1917), 187-90.

intention of the legislation was to alleviate the possibility that a massive pension scheme would take hold, as had been the case following the Civil War of approximately sixty years prior. One of the primary goals of the War Risk Insurance Act, in fact, was to help create a sense of responsibility among those who served, even as they capitalized on government benefits. Although compensation in the form of pensions “is a helpful measure of justice,” Secretary of the Treasury William G. McAdoo, Jr. argued, “rehabilitation and reeducation, fitting him for a life of activity and usefulness, either in his former or some other vocation, is an obligation fundamental both to him and his fellow men.”<sup>5</sup> The WRIA did not address the complicated issue of vocational education – that would arise later – but it did bolster the notion of personal responsibility in another way: the legislation would be modeled on workmen’s compensation acts rather than on pension systems of the past. This meant that compensation would be determined by one’s personal situation, with a focus on the beneficiary’s number of dependents. It also meant that the individual would be obligated to abide by the terms of the bill by, for example, submitting to regular medical check-ups, in order to continue receiving payments.

The central premise behind adopting such a model was that soldiers and veterans should receive certain benefits based on both the extent of their disability and their personal backgrounds as civilians, not merely because they had served. “The great outcry against the compensation system had not been due to the moneys that were paid to the men who died or were disabled because of injuries received while serving this country,” declared Julian Mack during hearings regarding the WRIA, referring to the public reaction following the Civil War. “The outcry,” he said, came with the establishment of the service pension legislation in the

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<sup>5</sup> To Amend the Bureau of Insurance Act So as to Insure the Men in the Army and Navy, Hearings before the Committee on Interstate and Foreign Commerce, H.R. 5723, Part 1, Sixty-Fifth Congress, First Session, (Washington, D.C.: Government Printing Office, August 11, 1917), 14.

1890s, which “aims to give a man a pension because he was a soldier, and sometimes a soldier for 30 days, and sometimes not much of a soldier at that for 30 days.”<sup>6</sup> As they debated the terms of the War Risk Insurance Act, Mack and his colleagues were pondering a deeper question, one that would arise surrounding veterans’ benefits repeatedly in the near future: should soldiers and veterans receive government entitlements strictly by virtue of past service in the armed forces (in other words, because they belonged to a distinct group of citizen-veterans), or should the nature of that service, and other considerations apply?

Mack, a lawyer and judge by trade, was summoned by his government to help plan for the compensation and insurance of soldiers and sailors because of his reputation as an important Progressive reformer. In the 1910s, he called on his good friend Jane Addams to help him manage the affairs of “the first children’s court in the world” in Chicago, Illinois. There, he implemented his credo that a child offender who entered the court “should, of course, be made to know that he is face to face with the power of the state, but he should at the same time, and more emphatically, be made to feel that he is the object of its care and solicitude.”<sup>7</sup> The perspective that a soldier’s social status and background should determine his level of compensation was firmly rooted in the Progressive Era ideologies of Mack and his fellow reformers. In juvenile cases, Mack wrote in 1909, “the problem for determination by the judge is not, Has this boy or girl committed a specific wrong, but What is he, how has he become what he is, and what had best be done in his interest and in the interest of the state to save him from a downward career.”<sup>8</sup>

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<sup>6</sup> To Amend the Bureau of Insurance Act So as to Insure the Men in the Army and Navy, Hearings before the Committee on Interstate and Foreign Commerce, H.R. 5723, Part 2, Sixty-Fifth Congress, First Session, (Washington, D.C.: Government Printing Office, August 17, 1917), 73.

<sup>7</sup> The first quote is from "Julian W. Mack, 1866-1943," *Social Service Review* Vol. 17, no. No. 4 (December 1943). The second quote is from Julian W. Mack, "The Juvenile Court," *Harvard Law Review* Vol. 23, no. No. 2 (1909): 120.

<sup>8</sup> Mack, "The Juvenile Court," 120.

The government, Progressives strongly believed, could be a force for good not only in regulating industry, but also in reforming the behavior of individuals – not least of all those who were poor or not fully “Americanized.”<sup>9</sup>

When making their case regarding former soldiers, social reformers could note a long tradition of government action. An array of scholarship points out that, since the eighteenth century, veterans in the United States have been granted unique government entitlements. The Revolutionary War Pension Act of 1818 served as a poor law of sorts; veterans who could demonstrate financial need received annual payments up to \$240. After the Civil War, federal pensions were re-figured with the intention of limiting the number of potential beneficiaries: benefits would be contingent on one’s degree of disability, lawmakers mandated. But thanks in large part to the eagerness of politicians to gain the favor of veterans as a voting bloc, coverage was gradually expanded over time; by the late 1880s, more than one-third of all elderly men living in the North, as well as men, widows and dependents of veterans across the nation, received quarterly payments from the U.S. Pension Bureau.<sup>10</sup>

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<sup>9</sup> For more on Mack, see Harry Barnard, *The Forging of an American Jew: The Life and Times of Judge Julian W. Mack* (New York, New York: Herzl Press, 1974). The literature on progressivism in the U.S. is vast and wide-ranging. See, for example, James J. Connolly, *The Triumph of Ethnic Progressivism: Urban Political Culture in Boston, 1900-1925* (Cambridge, Massachusetts; London: Harvard University Press, 1998). Elizabeth Sanders, *Roots of Reform: Farmers, Workers, and the American State 1877-1917* (Chicago, Illinois: University of Chicago Press, 1999). Alan Dawley, *Changing the World: American Progressives in War and Revolution* (Princeton, New Jersey; Oxford: Princeton University Press, 2003). Daniel T. Rodgers, *Atlantic Crossings: Social Politics in a Progressive Age* (Cambridge, Massachusetts; London: Belknap Press of Harvard University, 1998).

<sup>10</sup> The information pertaining to the U.S. Pension Bureau is cited in Theda Skocpol, *Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States* (Cambridge, Mass.: Belknap Press of Harvard University Press, 1992), 1. For a concise summary of the history of veterans’ benefits, see: Beth Linker, *War’s Waste: Rehabilitation in World War I America* (Chicago, Illinois: University of Chicago Press, 2011), 13-27. Chapter Six of this dissertation will delve further into parallels between Civil War and World War I failures to limit numbers of veteran beneficiaries. For a somewhat celebratory account of the evolution of the veterans’ benefits system, see: Karen Cleary Adlerman and Sar A. Levitan, *Old Wars Remain Unfinished; the Veteran Benefits System* (Baltimore: Johns Hopkins University Press, 1973).

As historian Patrick J. Kelly notes, while land and monetary payments were made to veterans throughout the nineteenth century, institutional assistance “emerged much more slowly.” Asylums and hospitals were difficult to maintain and, as Kelly puts it, “they smacked of monarchical institutions like France’s Hotel des Invalides.”<sup>11</sup> In the years following the Civil War, however, as the middle and upper class reform groups which had proactively taken charge of veterans’ care found themselves increasingly financially strapped, such institutions became impossible to avoid, and a national system of soldiers’ homes was established. By 1900, eight branches existed, which had housed more than 100,000 union veterans in states across the country, including Ohio, Wisconsin, Maine, and Virginia. At many of these institutions, hospitals were maintained on vast campuses along with residences and workshops. But the primary purpose of the soldiers’ homes was not to provide medical care; instead, they were intended to serve as somewhat domestic environments for war veterans, most of whom were single men with few other options.<sup>12</sup>

Although it fit into a long tradition of the U.S. government granting entitlements for veterans, the World War I era War Risk Insurance Act was a product of its time, and marked a breaking point in many respects. The turn of the twentieth century witnessed changing ideals of medical care, as well as the passage of federal social legislation regarding workplace safety and health. Both of those broad societal trends directly influenced pre-war policies regarding hospital care for soldiers and veterans. The War Risk Insurance Act contained a stipulation that veterans would be provided with “hospital services and supplies,” because hospitals were, in the lead-up

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<sup>11</sup> Patrick J. Kelly, *Creating a National Home: Building the Veterans' Welfare State, 1860-1900* (Cambridge, Mass.: Harvard University, 1997), 2-3. The use of soldiers’ homes in the treatment of World War I veterans will be discussed in Chapter Four.

<sup>12</sup> Ibid.

to World War I more than during any other conflict, considered to be ideal sites of care. Until the 1880s, disease was not thought to be random, but a form of retribution for social deviance, best treated in almshouses and charity hospitals which advocated moral, as well as hygienic, behavior.<sup>13</sup> But by the turn of the twentieth century, both the rich and poor accessed care in hospitals, which were by then thought to provide certain amenities unattainable in the home: a sanitary environment and medical technologies, such as the X-ray. In 1873, 178 hospitals existed in the United States. By 1909, there were more than 4,300.<sup>14</sup> These hospitals were products of new understandings of disease pathology, changing socioeconomic conditions, and the advent of an industrial economy. They were also products of a distinctive Progressive Era approach to science and medicine focused on efficiency, economy, and a new understanding of bacteriology.

Various historians argue that hospitals went from serving as moralistic, charitable institutions in the nineteenth century to focusing heavily on medical problems and which technologies could alleviate them in the early twentieth century. But scholars differ as to why such a change came about. David Rosner and Morris Vogel emphasize that it was not just medical and scientific advances such as the germ theory of disease that allowed hospital administrators to claim that their facilities could provide better care than that available in the home. A popular turn toward institutional medical care, Rosner notes, was less a sign of unflinching scientific progress than it was a reflection of new material realities emerging from industrialization. As socioeconomic conditions changed at the turn of the twentieth century, in other words, so did the purpose and perceptions of hospitals. During the depression of the 1890s, Rosner explains, New York municipalities ceased reimbursing hospitals on a per capita basis for

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<sup>13</sup> Charles E. Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (New York: Basic Books, 1987), 121.

<sup>14</sup> *Ibid.*, 5.



the immigrant “charity cases” that flooded hospital wards. Thus, hospital trustees became cost-conscious and business-focused, and increasingly aimed to attract paying patients. Economic need, political realignment, and urban expansion forced trustees to turn to doctors as a source for middle- and upper-class patients. Thus, changes brought about by industrialization, Rosner argues, led to the broad and lasting transformation of hospital care.<sup>15</sup> Charles Rosenberg takes a more internalist view, arguing that the move toward a clinical focus was attributable largely to the increasing power of doctors as an interest group, and their drive to use the hospital as an arena to promote their own professional self-interest.<sup>16</sup> Rosemary Stevens points to various factors as shapers of hospital care: newly available medical technologies, the advent of university medical education that relied on a partnership with hospitals, and the larger paradox of the hospital as a communal, charitable institution that was, to a large extent, motivated by a necessity for profit.<sup>17</sup>

In addition to being shaped by larger social and demographic realities and transformations in the world of professional medicine, the War Risk Insurance Act was ideologically modeled on contemporary legislation focusing on various aspects of workers’ rights, from minimum wage laws to workplace safety standards. In the years surrounding World War I, 25 states passed workers’ compensation laws, prompted by the advocacy efforts of a “coalition of radicals, reformers, labor leaders, and even business representatives” who believed the newly powerful United States was “woefully behind the industrialized European community”

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<sup>15</sup> David Rosner, *A Once Charitable Enterprise* (Cambridge: Cambridge University Press, 1982). For an externalist view of hospital development that focuses more on politics: Morris J. Vogel, *The Invention of the Modern Hospital: Boston, 1870-1930* (Chicago: University of Chicago Press, 1980).

<sup>16</sup> Rosenberg, *The Care of Strangers: The Rise of America's Hospital System*.

<sup>17</sup> Rosemary A. Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (New York: Basic Books, 1989).

in guaranteeing workplace health and safety standards.<sup>18</sup> The years between 1910 and 1920, then, marked a distinct moment in which advocates increasingly called on the government to recognize that workers had certain inherent rights that were worthy of protection. The fact that the War Risk Insurance Act went further than previous legislation aimed at veterans fits within this context. Soldiers and veterans were, after all, at the simplest level, *employees* of the federal government.

The composition of the army was also an important factor in the shaping of the WRIA. Authors of the Act argued that conscript soldiers, in many respects, deserved more than volunteers or career soldiers or officers. Although many Civil War soldiers had been conscripted, World War I was the first conflict during which the majority of troops were drafted into service. Secretary of the Treasury William G. McAdoo argued that the U.S. government thus had a weighty responsibility in the current conflict:

We are not relying on the volunteer system in this war. We are drafting men and compelling them to make, if necessary, the supreme sacrifice for their country. A higher obligation, therefore, rests upon the government to mitigate the horrors of war for the fighting men and their dependents in so far as it is possible to do so through compensations, indemnities, and insurance. Less than this, a just, generous and humane government can not do. We must set an example to the world, not alone in the ideals for which we fight, but in the treatment we accord to those who fight and sacrifice for us. ... (soldiers) should know that if they are disabled, totally or partially – if they come back armless, legless, sightless or otherwise permanently injured – definite provision is made for them, and that they are not going to be left to the uncertain chances of future legislation or to the scandals of our old pension system. Every man should know that the moment he is enlisted in the military service of the government, these definite guarantees and assurances are given to him not as charity but as a part of his deserved

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<sup>18</sup> Gerald Markowitz and David Rosner provide a useful overview of worker safety laws in the United States, and government involvement in workers' health in the Introduction to *Dying for Work: Workers' Safety and Health in Twentieth-Century America* ed. David Rosner and Gerald Markowitz (Bloomington: Indiana University Press, 1989). Also see David Rosner; Gerald Markowitz. "The Early Movement for Occupational Safety and Health, 1900-1917." In *Sickness and Health in America: Readings in the History of Medicine and Public Health*, edited by Judith Walzer; Numbers Leavitt, Ronald N. Madison, Wisconsin; London: University of Wisconsin Press, 1997. p. 467-481.

compensation for the extra-hazardous occupation into which his government has forced him.<sup>19</sup>

Julian Mack agreed. He argued that men who enlisted voluntarily in the armed forces as individuals could be “dealt with... alone” by the government through monetary payments for losses of limbs and the like. “But in these days of the draft and conscription,” Mack said, “when you take a man away from his family against his will the family ought to be considered as the unit not only in arriving at the man’s compensation.”<sup>20</sup>

Mack’s statement makes it clear that the WRIA focused first and foremost on the government’s responsibility to a soldier’s family; it emphasized the importance of seeing the soldier not as a man alone, but as a husband, father, and provider. When the legislation is seen in this light, it is easier to understand why legislators overlooked the details of how soldiers and veterans could access personal medical care following their service: dependency – whether on a hospital or any other institution – was the antithesis of the endpoint to which policymakers aspired in the pre-war years.

As they debated the WRIA in the summer of 1917, some predicted that the legislation would lead to subsequent demands for more benefits. John A. Key (D—OH), Chairman of the Committee on Pensions, predicted that, “should the pending bill be enacted with its present provisions... within a year from the date of its passage, Congress will be flooded by bills, seeking by special acts of Congress individual cases to adjust, rectify, and remove the

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<sup>19</sup> To Amend the Bureau of Insurance Act So as to Insure the Men in the Army and Navy, Hearings before the Committee on Interstate and Foreign Commerce, H.R. 5723, Part 1, 16.

<sup>20</sup> To Amend the Bureau of Insurance Act So as to Insure the Men in the Army and Navy, Hearings before the Committee on Interstate and Foreign Commerce, H.R. 5723, Part 2, 85.

inequalities and injustice.”<sup>21</sup> In fact, the WRIA led not only to a flood of complaints regarding individual cases, but also laid the groundwork for the establishment of a nationwide veterans’ hospital system. Key’s words proved prophetic.

Others, however, took the stance that decisive action was necessary as mobilization moved quickly forward. Supporters of the WRIA argued that unique times called for drastic – and hasty – measures. “When it comes to saying exactly what should be offered at the end of the war, it is a little difficult to formulate it in two or three weeks, and to say exactly what is practicable,” noted Philemon Tecumseh Sherman, a New York lawyer who specialized in workmen’s compensation, unemployment, and old-age insurance, regarding details in the WRIA’s insurance plan. “We left the exact formulation of that to be determined later.”<sup>22</sup>

Multiple scholars have brought to light the main components of the WRIA and pointed out its historical relevance. William H. Glasson called it a “radical departure from the existing pension system.”<sup>23</sup> Beth Linker concurs, pointing out that the Act was written by prominent anti-pension Progressives who “saw medical rehabilitation as a means of conservation, a way to preserve the nation’s economic and human resources.”<sup>24</sup> K. Walter Hickel argues that it was not only a “crucial step in the codification, institutionalization and reification of (a) medical

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<sup>21</sup> To Amend the Bureau of Insurance Act So as to Insure the Men in the Army and Navy, Hearings before the Committee on Interstate and Foreign Commerce, H.R. 5723, Part 3, 183-85.

<sup>22</sup> Ibid., 166. During the war, Sherman served as a member of the Labor Committee of the Advisory Commission of the Council of National Defense, which also shied away from the question of how to structure veterans’ medical care. The son of famed Civil War Union Army General William Tecumseh Sherman, P. Tecumseh Sherman served on the New York Board of Aldermen from 1888-1889 and as New York State Commissioner of Labor from 1905-1907. According to one obituary, “his advice on compensation and insurance problems was sought by many states...” “P.T. Sherman Dies; Son of General, 74,” *The New York Times* December 7, 1941.

<sup>23</sup> William H. Glasson, *Federal Military Pensions in the United States* (New York: Oxford University Press, American Branch, 1918).

<sup>24</sup> Linker, *War’s Waste: Rehabilitation in World War I America*, 35.

conception of disability...” but also served as a “formative step in welfare state building.”<sup>25</sup>

Rosemary Stevens, too, argues that the framers of the WRIA believed pensions were “unscientific,” but she notes that the Act also signified a trend of the times – the growing popularity of life insurance policies; there were 49 million private life insurance policies in effect in the US by 1917, Stevens notes, up from 25 million in 1907.<sup>26</sup>

To scholars who focus specifically on the medical care of veterans, the War Risk Insurance Act represents a valiant, but ultimately short-sighted effort. According to Stephen Ward, the very fact that Congress debated and passed the legislation marked a step forward in terms of preparedness, at least in comparison with efforts surrounding previous wars. But, Ward also notes, laws like the WRIA, which provided for hospitalization and pension benefits, “were often written without knowledge of the types of medical problems likely to arise during the war. What in fact constituted a legitimate basis for hospitalization was thus often vague and ill-defined.”<sup>27</sup> In their history of the Veterans’ Administration, Gustavus Weber and Laurence Schmeckebier point out that the War Risk Insurance Act’s stipulation that medical and surgical hospital services would be provided for ex-servicemen led to “one of the most complicated and difficult tasks ever undertaken by the federal government.”<sup>28</sup> In other words, although the Act did not itself establish a veterans’ hospital system, the rights it guaranteed eventually helped bring about medical welfare for millions of veterans.

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<sup>25</sup> Hickel, "Entitling Citizens: World War I, Progressivism, and the American Welfare State, 1917–1928", 105-07.

<sup>26</sup> U.S. Bureau of the Census, Statistical Abstract of the United States, 1919, Washington, DC: US Government Printing Office, 1920, p. 645, cited in Rosemary A. Stevens, "The Invention, Stumbling, and Re-Invention of the Modern U.S. Veterans Health Care System, 1918-1924," in *Veterans' Policies, Veterans' Politics: New Perspectives on Veterans in the Modern United States*, ed. Stephen R. Ortiz (Gainesville: University Press of Florida, 2012).

<sup>27</sup> *The War Generation: Veterans of the First World War*, ed. Stephen R. Ward (London: Kennikat Press, 1975), 42.

<sup>28</sup> Gustavus Adolphus Weber and Laurence Frederick Schmeckebier, *The Veterans' Administration, Its History, Activities and Organization* (Washington, D.C.: Brookings Institution, 1934), 154.

### *The Council of National Defense Medical Board*

While the WRIA established the legislative tone for the conceptualization of medical care for soldiers and veterans, meetings of the Council of National Defense Medical Board between April 1917 and June 1918 serve as a window on to the changing priorities of government officials, military personnel, doctors, and other professionals. In its early days – as the U.S. government declared war on Germany in April 1917, established the military draft in May 1917, and passed the War Risk Insurance Act in June 1917 – the CND Medical Board concerned itself largely with the war’s affect on a distinguished and changing profession. Over time, in addition to serving as a forum for professional concerns of civilian doctors, the CND Medical Board became a sort of clearinghouse for information. Surgeons General of the Army, Navy, and Public Health Service, as well as officials of the Red Cross, used its meetings to share with each other organizational activities. Even as they exchanged information, representatives of these entities continued to work independently of one another, completing the portion of war preparedness work for which each was respectively responsible. As “a veritable patchwork of public and private institutions” helped to stock and sanitize military camps and train and examine soldiers, they focused more on their own organizational goals than on taking a wide-angle view of all prospective pre-war needs, including planning for the post-war care of veterans.<sup>29</sup> At various CND meetings, officials pointed out the need for non-military hospitals that could address the specific health needs of former service members, but argued that the problem was too vast to be addressed hastily or piecemeal. Everyone acknowledged the problem, but no one directly addressed it.

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<sup>29</sup> The phrase is from Carol R. Byerly, *Fever of War: The Influenza Epidemic in the U.S. Army During World War I* (New York; London: New York University, 2005), 42.

Created under an act of Congress in August 1916, and fully organized in March 1917, the CND was charged with the “coordination of industries and resources for the national security and welfare” and the “creation of relations which will render possible in time of need the immediate concentration and utilization of the resources of the nation.” It consisted of the Secretaries of War, the Navy, Agriculture, Commerce, and Labor, who were responsible for electing seven representatives “with special knowledge” of a specific industry or natural resource, or who were “otherwise specially qualified...” In its first annual report released in June 1917, the CND self-consciously declared a phenomenon that scholars would later analyze: “It has become a truism that no past war has been so essentially a war of the mechanic and the machine, and it is the realization of this truth that has been the inspiration of the policy pursued by the council...”<sup>30</sup> The bulk of CND activities had to do with large industry – for example, coordinating railroad operation and “managing” conflicts between labor and capital. The seven chosen Council representatives included the civic and business elites of the day: Daniel Willard, president of the Baltimore & Ohio Railroad, oversaw transportation and communications; Julius Rosenwald, president of Sears Roebuck & Co. was in charge of supplies; banker Bernard M. Baruch coordinated raw materials, minerals, and metals; American Federation of Labor president Samuel Gompers managed labor issues. The Council, on the whole, was emblematic of what Alan Brinkley refers to as “a brief experiment in state management of the economy,” one that fulfilled the hope of Progressives and many others that “government, capital, and labor” could cooperate “on behalf of a great national mission.”<sup>31</sup>

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<sup>30</sup> First Annual Report of the Council of National Defense for the Fiscal Year Ended June 30, 1917, S. Doc. 156, , Sixty-Fifth Congress, Second Session, (Washington, DC: Government Printing Office, November 20, 1917).

<sup>31</sup> Alan Brinkley, *Liberalism and Its Discontents* (Cambridge, Massachusetts; London: Harvard University Press, 1998), 80. For historical renderings of the CND, see: Ellis W. Hawley, *The Great War and the Search for a Modern Order* (New York: St. Martin's Press, 1979). According to David M. Kennedy, who focuses on the Council's efforts

Among the “industrial” representatives on the CND, Chicago surgeon Franklin H. Martin was tasked with heading efforts concerning medicine and surgery. A personal friend of Army Surgeon General William C. Gorgas, Martin’s career was emblematic of “a virtual revolution” taking place in the medical profession and its affiliated institutions; at the turn of the twentieth century, the increasingly powerful American Medical Association promoted the implementation of universal standards for medical education as medical specialization increased, and the practice of surgery – separate and apart from general practice – gained respectability.<sup>32</sup> During these years, Martin helped establish the journal, *Surgery, Gynecology and Obstetrics*, and regularly served as an active member of local and state medical societies. In 1913, he helped to found, and became Director-General, of the American College of Surgeons, an organization that had a mission ranging from hospital standardization to passing guidelines for the proper care of fractures and malignant diseases.<sup>33</sup>

Martin did not have to search far for the personnel or structure of his CND General Medical Board; he had a prototype in the Committee of American Physicians for Medical Preparedness, which had been formed in April 1916 by joint action of the presidents of the American Medical Association, the American Surgical Association, the Congress of American Physicians and Surgeons, and the Clinical Congress of Surgeons of North America. Members of

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to mobilize economic sectors, such as railroads and food, CND officials had a “charge [that] was at once sweeping and vague; their power potentially large but formally nil.” David M. Kennedy, *Over Here: The First World War and American Society* (New York: Oxford University Press, 1980), 115. For more on wartime government, see Christopher Capozzola, *Uncle Sam Wants You: World War I and the Making of the Modern American Citizen* (New York: Oxford University Press, 2008). Frederic L. Paxson, “The American War Government, 1917-1918,” *The American Historical Review* Vol. 26, no. No. 1 (Oct. 1920).

<sup>32</sup> On the emergence of medical specialties (including the rise of surgery), see Rosemary A. Stevens, *Medicine and the Public Interest: A History of Specialization* (Berkeley and Los Angeles, California: University of California Press, 1998). The quote is from p. 149.

<sup>33</sup> John S. O’Shea, “Responding to Crisis: Franklin H. Martin, the A.C.S., and the Great War,” *Bulletin of the American College of Surgeons* 89, no. 6 (June 2004). John E. Jennings, “Franklin H. Martin, 1857-1935: A Retrospect and an Appreciation,” *Annals of Surgery* 101, no. 4 (1935).



this national entity, aware that Congress was debating the National Defense Act, quickly organized nine-member state committees with two overarching duties: to obtain information regarding medical resources in local communities, and to secure applicants for the Army Medical Reserve Corps.<sup>34</sup> When the Committee of American Physicians for Medical Preparedness offered its services to President Woodrow Wilson soon after its formation, Wilson replied that he was “regretful that existing laws did not permit the acceptance by the federal government of gratuitous services.” But the administration managed to get around the problem by asking the Committee to do its work under the auspices of the CND, thus capitalizing on the power and considerable reach of the private sector group.<sup>35</sup> With the formation of the CND Medical Board, prominent American medical professionals went from meeting and corresponding privately, to serving as officially sanctioned experts for the federal government. Professors of medicine, municipal health officials, and officers of professional organizations oversaw a variety of committees on war-related topics such as shell shock, ophthalmology, surgical methods, cardiovascular impairment, drug addiction, tuberculosis, public health nursing, and alcohol, among others.

Throughout 1917, questions regarding how the war would affect health professionals dominated CND General Medical Board meetings. Its members worked to gain support from Congressional representatives for measures exempting medical students from the draft, and establishing higher rank and pay for doctors who enlisted in the military. The Medical Board also

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<sup>34</sup> For more on the relationship between the National Defense Act and the Committee of American Physicians, see Frank W. Weed Charles Lynch, and Loy McAfee, *The Medical Department of the United States Army in the World War, Volume 1: The Surgeon General's Office* (Washington, D.C.: Government Printing Office, 1923), 73-80.

<sup>35</sup> "Information Regarding the Correlated Activities of the Council of National Defense and the Advisory Commission, the Medical Departments of Government, and the Committee of American Physicians for Medical Preparedness". Council of National Defense, Record Group 62, Box 417, Medicine and Sanitation Committee, National Archives and Records Administration, College Park, MD.

attempted to establish professional standards for those who remained at home. It ordered doctors who took on patients of colleagues who were sent “over there” to cap their fees, and abstain from permanently winning over patients to their own practices. The Medical Board also spent much time organizing state committees to coordinate enlistment drives. Civilian professional groups thereby assisted the army in reaching its quota of wartime doctors. Further to this cause, the Medical Board assisted with the staffing of a Medical Reserve Corps, which allowed medical students an alternative to being drafted into enlisted service. In addition, it helped to coordinate stipulations for medical suppliers who intended to do business with the government.<sup>36</sup>

Meetings of the Medical Board also served as a forum for the exchange of information, where the Surgeons General of the Army, Navy, and Public Health Service (PHS) provided concise reports of their activities surrounding physical examinations of troops, base camp and ship sanitation, and staffing of medical personnel. Reports of the Public Health Service, for example, focused on the main components of that organization’s war-related work: hygiene and sanitation in military camps and the communities surrounding them. Aside from reporting on the Public Health Service’s sanitary work, PHS Surgeon General Rupert Blue also lobbied actively at CND meetings for a comprehensive study of the health of industrial workers in war industries, which he argued was necessary for efficient mobilization.<sup>37</sup> Blue, an advocate of compulsory sickness insurance and the advancement of workers’ health, evidently hoped to use wartime mobilization as a means by which to pursue a long-held professional passion. In this, he was not alone. Many understood that with the frenzy of war came opportunity. Professional

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<sup>36</sup> "Correspondence, April 1917-June 1918 ". Council of National Defense, Record Group 62, Box 417, Medicine and Sanitation Committee, National Archives and Records Administration, College Park, MD.

<sup>37</sup> "Council of National Defense General Medical Board Meeting Minutes, December 9, 1917". Council of National Defense, Record Group 62, Box 426, General Medical Board, Secretary’s Office, National Archives and Records Administration, College Park, MD.

advancement, for example, was a priority of women physicians, orthopedists, and dentists, all of whom participated in CND meetings and argued that they should enjoy equal access to work as part of the United States military effort.<sup>38</sup> Reports of the PHS and other organizations show that preparing for war left few resources within already strapped organizations to devote to the seemingly distant concern of providing care for soldiers with chronic conditions and wounded and ill veterans

Various parties, however, rightfully predicted that there would be some demand for after-care. In April 1917, a member of the Board's hospital committee noted that a "previous report" had recommended that the CND be "given authority to consider the ultimate need of special hospitals or facilities for the care of special groups of cases such as neurological, orthopedic, mental, those suffering from shell shock, etc." But "in order to guard against the duplication of work, it was voted that the chairman be requested to determine whether or not they (*sic*) desire this committee to take up this problem and to organize these special hospital facilities..." To be sure, the representative noted, "the committee is ready to be of service in every possible way, in undertaking constructive work, but it wishes to avoid duplication of work which may already be provided for in some other way."<sup>39</sup> In its May 13, 1917 report to the Medical Board, the CND hospital committee acknowledged that "a study of the ultimate need of convalescent hospitals, and a large group of special hospitals such as shell shock, orthopedic, cardiac, etc." was "of such

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<sup>38</sup> On the recruitment of civilian doctors, and the struggle for representation by African American and white women professionals, See Byerly, *Fever of War: The Influenza Epidemic in the U.S. Army During World War I*, 25-32. On women's attempts to advance citizenship rights via the military, see Kimberly Jensen, *Mobilizing Minerva: American Women in the First World War* (Urbana, Illinois: University of Illinois Press, 2008). Also, Judith Bellafaire and Mercedes Herrera Graf, *Women Doctors in War* (College Station, Texas: Texas A&M University Press, 2009). Mercedes Graf, "With High Hopes: Women Contract Surgeons in World War I," *Minerva* XX, no. 2 (2002).

<sup>39</sup> "Council of National Defense General Medical Board Meeting Minutes, April 22, 1917", 29-31. Council of National Defense, Record Group 62, Box 426, General Medical Board, Secretary's Office, National Archives and Records Administration, College Park, Maryland.

magnitude and requires so much detailed and special information, most of which can only be obtained from the sanitary service of our allies, that your committee feels this work is quite beyond this committee..." The Medical Board thus rescinded the responsibility of deliberating the provision of extensive hospital services and suggested the issue be addressed by the Army Surgeon General's Office.<sup>40</sup> In the winter of 1917 and the spring of 1918, the topic of hospital care rarely came up in CND Medical Board meetings.

But the related subjects of civilian and military cooperation in the administration of medical care for soldiers, including the idea of facility-sharing (both crucial issues during and after the war) were discussed within the professional medical community. In December 1917, Dr. Sigismund Shulz Goldwater of the American Hospital Association told the CND Medical Board that his association "deplored the fact" that the army did not want to utilize "existing institutions." Given the fact that the "Army must be sure of preparation, must have absolute control of everything it does, Goldwater conceded, it was "easy to understand" why it must oversee care of its own personnel." Still, he argued, "there are instances in which private institutions and hospitals can be utilized to advantage." He urged the powers that be not to "assume that the hospitals already existing have nothing to contribute."<sup>41</sup>

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<sup>40</sup> "Council of National Defense General Medical Board Meeting Minutes, May 13, 1917", 21-22. Council of National Defense, Record Group 62, Box 426, General Medical Board, Secretary's Office, National Archives and Records Administration, College Park, Maryland.

<sup>41</sup> "Council of National Defense General Medical Board Meeting Minutes, December 9, 1917", 29. Ironically, perhaps, the army demonstrated more willingness to rely on the efforts of the civilian medical profession in the organization of base hospitals abroad than it did in the administration of domestic care. As early as 1915, its Medical Department began marshaling the resources of the American Red Cross, American medical schools, and civilian hospitals in an effort to expeditiously provide base hospitals (along with the personnel necessary to staff them) abroad. These units, the first of which served the British Expeditionary Forces, came to play a crucial role in the army's military medical efforts near the front. There are scant secondary sources on this expansive and interesting military-civilian hybrid wartime effort. For a useful contemporary account, see Harvey Cushing, *From a Surgeon's Journal, 1915-1918* (Boston, Massachusetts: Little, Brown, and Company, 1936), especially Chapter III. Also, United States Army Surgeon General, *History of United States Army Base Hospital No. 20, Organized at the University of Pennsylvania* (Philadelphia, Pennsylvania: E.A. Wright Company, 1920). For a concise overview of the base hospital system abroad, see Mary C. Gillett, *The Army Medical Department, 1917-1941* (Washington, D.C.:

Goldwater elaborated on the issue in the pages of *Modern Hospital* magazine. That journal, which began monthly publication in 1913, contained news of relevance regarding the fast-changing landscape of American medical institutions; articles focused on issues ranging from ideal construction plans to emerging clinical specialties.<sup>42</sup> In mid-1918, Goldwater sat on the editorial board of *Modern Hospital* along with Henry M. Hurd, Frederic A. Washburn, Winford H. Smith, W.L. Babcock, John A. Hornsby, and M.K. Chapin, who constituted a tight circle of some of the most prominent civilian hospital policymakers of the day. Winford Smith, for example, succeeded Hurd as the superintendent of the prestigious Johns Hopkins Hospital, and served in that post from 1911 through 1946. All the while, he assisted in the planning and organization of some of the country's most prominent medical centers: Duke, Cornell, Vanderbilt, and Yale Universities, as well as the Universities of Chicago and California. Smith, like many other highly respected doctors, served in both World War I and World War II.<sup>43</sup> In the years surrounding the Great War, the pages of *Modern Hospital* revealed that these professional men balanced their concerns for civilian medical practice with what they understood as the necessities of war.

Goldwater's April 1918 *Modern Hospital* article highlighted the fact that some in the civilian medical world viewed with unease the concept of a distinct military health care system.

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Center of Military History, United States Army, 2009), 28-31, 260-66. On the wartime activities of Columbia University's Columbia-Presbyterian Hospital, see: Albert R. Lamb, *The Presbyterian Hospital and the Columbia-Presbyterian Medical Center, 1868-1943: A History of a Great Medical Adventure* (New York: Columbia University Press, 1955), 108-48.

<sup>42</sup> Broadly speaking, the magazine was "devoted to the building, equipment, and administration of hospitals, sanatoriums, and allied institutions, and to their medical, surgical, and nursing services." "Magazine Slogan, Noted on Title Page," *Modern Hospital Magazine* Vol. 8, No. 1 (January 1917).

<sup>43</sup> Background on Smith's life and work is included in a description of his personal papers: The Johns Hopkins Medical Institutions Alan Mason Chesney Medical Archives, "Biography of Winford H. Smith, [Http://www.Medicalarchives.Jhmi.Edu/Papers/Smith\\_Wh.html](http://www.Medicalarchives.Jhmi.Edu/Papers/Smith_Wh.html)."

“The time of military officers would be wasted,” Goldwater argued, “if devoted to the care of physical wrecks returned from France, this being a job for a civilian, not a military man.”

Goldwater was not taking issue with the idea that the Army Medical Department should maintain control of some cases – soldiers who fell ill at cantonments, for example, or those who were being cared for at or near the front lines. He was concerned mainly with the domestic care of the severely wounded and seriously ill. “The extension and development of existing civil hospitals and sanatoriums under government direction, in accordance with a Government program, and with the support of Government funds,” he argued, “may conceivably be a better way of providing the additional facilities required than the purchase of hospitals sites in localities remote from the centers of population, and the erection, upon such sites of costly ‘special military hospitals...’” The latter, Goldwater said, would have difficulty attracting “competent staffs” which could be retained after the war. Goldwater urged the government to undertake a comprehensive study of domestic civil hospitals to ascertain how they could serve in the war effort.<sup>44</sup>

The question of civilian versus military control was especially vexing when it came to the issue of vocational education, which pre-war planners included as a crucial aspect of an injured soldier’s “cure.”<sup>45</sup> In England, Council of National Defense representatives pointed out, participation in vocational rehabilitation programs was optional, and enrollment was only about

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<sup>44</sup> S.S. Goldwater, "Soldiers and the Civil Hospitals," *Modern Hospital Magazine* Vol. X, No. 4 (April 1918). Goldwater’s perspective went against the predominant trend described by Rosemary A. Stevens, who notes that, “no (civilian) general hospital worth its salt – standardized or un-standardized – wanted to treat the long-term conditions presented by the majority of veterans.” Only in the mid- to late-1920s, when civilian doctors believed the government was encroaching too far into veterans’ health care, did they begin to fight en masse for the private sector control Goldwater advocated as early as 1918. Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*, 126-31.

<sup>45</sup> On the pre-war history of vocational education and its use during and after World War I, see Linker, *War’s Waste: Rehabilitation in World War I America*, 148-66.

15 percent.<sup>46</sup> A report from the Conference on Reeducation and Rehabilitation of the Maimed and Crippled noted that “the establishment of reconstruction hospitals, or hospital schools, for the repair of cripples and disabled persons is essential,” and that such institutions should be “widely distributed,” “large rather than small,” and “under military control.” “It has been found that many disabled soldiers in European countries would not undertake reeducation, and apparently preferred to be permitted to remain helpless and, thus, a social liability,” the report noted. “Every man should be compelled to undertake to learn an occupation that will enable him to be self-supporting or partly self-supporting.” Jefferson R. Kean, Director of Military Relief for the American Red Cross concurred with the report’s findings. While treating soldiers abroad, he said, “it was impossible to accomplish anything with these men unless they were under military discipline and treated as soldiers until repair work has been completed. The problem is military and should be under military control.”<sup>47</sup> In March 1918, Charles H. Mayo, Chairman of the CND Committee on Surgery and co-founder of Minnesota’s famed Mayo Clinic, expressed his staunch support of this policy. “The Surgeon General has full control of the men in the army until they are discharged,” he said. “This is exactly as it should be and it is fortunate for us. So, military medical and surgical service will reconstruct disabled men.”<sup>48</sup> In other words, the United States should keep men soldiers until they could be discharged as workers, or at least as semi-independent.

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<sup>46</sup> "Council of National Defense General Medical Board Meeting Minutes, December 9, 1917", 26-29.

<sup>47</sup> "Council of National Defense General Medical Board Meeting Minutes, June 24, 1917". Council of National Defense, Record Group 62, Box 426, General Medical Board, Secretary’s Office, National Archives and Records Administration, College Park Maryland.

<sup>48</sup> "Council of National Defense General Medical Board Meeting Minutes, March 10, 1918", 15-16. Council of National Defense, Record Group 62, Box 426, General Medical Board, Secretary's Office, National Archives and Records Administration, College Park, Maryland.

One problem with such a policy was that it required the acquiescence of soldiers themselves, including many who sought to be discharged as soon as possible regardless of their physical state. In May 1918, Frank Billings, who oversaw the army's rehabilitation program, pointed out this looming dilemma: "Many will want to go out of the army," he said. "They have been abroad for months in an unusual environment and want to get out – they are homesick. We must create a sentiment to educate that soldier. He must not return to his home until he can make a living for himself better than he did before – until he can enjoy life."<sup>49</sup>

Others rightfully predicted that the rehabilitation project would gradually expand, and gain import among various groups as time passed, but all fingers pointed to the Army Medical Department as the proper entity to oversee hospital care for ailing soldiers, regardless of the likelihood that they would return to duty. The rehabilitation process "would have to go on for years after the war, and (large general hospitals) would take the place of the old Soldiers' Home as at present," Army Surgeon General William Gorgas said at a CND meeting in October 1917, but the long-term vision of such institutions was somewhat hazy:

"Some provisions will have to be made for these great hospitals after the war is over. That was discussed quite extensively in the recent insurance bill (the War Risk Insurance Act), which has been passed. We concluded to let that go and not decide the exact means of taking care of them until the time comes. If it was advisable for the War Department to continue control of these hospitals in the training process, we will do that. If some other machinery is thought advisable, we will use that method. But it seems to me if we get these institutions organized and running, it will be natural for the War Department to continue afterward these hospitals..."<sup>50</sup>

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<sup>49</sup> "Council of National Defense General Medical Board Meeting Minutes, May 5, 1918". Council of National Defense, Record Group 62, Box 426, General Medical Board, Secretary's Office, National Archives and Records Administration, College Park, Maryland.

<sup>50</sup> "Council of National Defense General Medical Board Meeting Minutes, October 21, 1917", 13-14. Council of National Defense, Record Group 62, Box 426, General Medical Board, Secretary's Office, National Archives and Records Administration, College Park, Maryland.



The Army Surgeon General, like the head of the CND hospital committee, knew that post-war hospital care and rehabilitation programs for veterans would be necessary, but pushed the matter aside as he focused on more immediate concerns.

Two months later, the topic came up at another CND meeting. “This is a subject that will attract the attention of every one on this side of the Atlantic as soon as the boy lands on the coast... It appeals to society, business men, to labor men, with whom they must compete, it appeals to vocational teachers, to general educational organizations, to great foundations that are seeking opportunity to spend money in the right direction,” said James Bordley of the Army Medical Department in December 1917. Still, he added, “it seems to me that this thing should be organized by the medical departments of the Army and Navy and coordinated with other activities in such a way that the reconstruction program may be carried out by the right people, in other words, the medical military men.”<sup>51</sup>

#### *Army plans for medical care and “reconstruction”*

Both the War Risk Insurance Act and the policies of the CND were based on the assumption that ex-soldiers should be discharged from the army only after they were medically rehabilitated. It followed that some of the most extensive plans for so-called reconstruction took place within the Army Surgeon General’s office, which, throughout 1917 and 1918, put forth proposals for a rehabilitation program that assigned military hospitals a central role in the provision of medical and therapeutic care. Based largely on the experiences of other belligerent nations, the army plans focused heavily (like the rhetoric of the WRIA) on the importance of industrial productivity and vocational training. They marked a drastic step away from the

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<sup>51</sup> "Council of National Defense General Medical Board Meeting Minutes, December 9, 1917", 29.

traditional tenets of military medicine and hinted at a new idealization of the notion of institutionalized comprehensive care involving doctors and therapists of various specialties.

Proposals for a sweeping army reconstruction plan faced many challenges. First, there were the fundamental logistical issues of expanding the available number of doctors and hospital beds. Then, there were conflicts about jurisdiction. As the army's newly created Department of Physical Reconstruction attempted to concoct plans for the aftercare of soldiers, civilian educators argued that it was inappropriate for the military to maintain control over individuals who would likely never return to duty. Such complex issues precluded the Office of the Surgeon General from quickly handing down a clear and comprehensive policy on rehabilitation. Thus, for the greater part of the war, American troops were treated in base and general hospitals in the U.S. according to rules dictated in a variety of General Orders from the War Department or, in many cases, the individual judgments of Medical Reserve Corps doctors in a given region or institution.

Between the summers of 1917 and 1918, as millions joined the ranks of the American Expeditionary Forces, and the consequences of war went from being theoretical to real, the army made hasty attempts to recruit doctors from the civilian world. In June 1916, the Army Medical Corps counted 443 active duty officers – doctors who were commissioned to work full-time with the military. There were also 146 officers on active duty in the Medical Reserve Corps.<sup>52</sup> On the eve of war, Col. Edward L. Munson, a Yale-educated army medical officer who specialized in training needs and methods, estimated that an army of one million men would require a Medical Department with 8,000 officers and 100,000 enlisted personnel. In order to fulfill the mandate, the army turned to the American Medical Association, which shared a membership roster that

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<sup>52</sup> Annual Report of the Surgeon General to the Secretary of War, 1918, (Washington, D.C.: Government Printing Office, 1918), 386.

included approximately two-thirds of the nation's physicians, as well as background files on “a most complete list of quacks, irregular practitioners, cults...” The AMA helped the army facilitate an extensive outreach campaign between May and September 1917. It consisted not only of solicitations in the Journal of the American Medical Association for doctors to serve, but also of the mailing of 69,000 letters to doctors across the country urging them to join the Medical Reserve Corps.<sup>53</sup> By June 30, 1918, there were 867 active duty Medical Corps officers, and 20,855 Medical Officers in the Reserve Corps. The latter number comprised about 14.5 percent of the United States’ approximately 146,300 physicians.<sup>54</sup>

In spite of an initial shortage of medical officers, army officials resisted the repeated appeals of white women and African American physicians, who lobbied for commissions during the war. As Carol Byerly has shown, these officials argued that it was untenable for white, male line officers to be commanded by anyone but white, male doctors. But as more and more sick and injured soldiers were discharged throughout 1918 and 1919, Army Medical Department administrators encountered an increasing need for doctors to serve on examining boards responsible for assigning degrees of disability. They were thus forced not only to hire women contract surgeons and African American doctors, but also people born outside the United States.<sup>55</sup> Although women were barred from serving as fully commissioned medical officers, 55 served as “contract surgeons,” and more than 80 served overseas with volunteer organizations such as the Red Cross.<sup>56</sup> Only a small percentage of African American physicians who wanted to

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<sup>53</sup> Gillett, *The Army Medical Department, 1917-1941*, 20-25.

<sup>54</sup> Annual Report of the Surgeon General to the Secretary of War, 1918, 386.

<sup>55</sup> Gillett, *The Army Medical Department, 1917-1941*, 50.

<sup>56</sup> Byerly, *Fever of War: The Influenza Epidemic in the U.S. Army During World War I*, 25-31. Mary Gillett also notes that 55 women served as contract surgeons with the Medical Department. Gillett, *The Army Medical*

serve were offered commissions. Largely limited to serve in black units, the 1.5 percent of medical officers who were African American reported experiencing racial discrimination in a Medical Corps that prided itself on being “fit and well-educated... white and male.”<sup>57</sup>

The entity that managed the medical care of soldiers – the Army Surgeon General’s Office – consisted of more than 20 divisions in the summer of 1917. Many were headed by temporary civilian recruits of the Medical Corps as opposed to career Army Medical Department officers, and each had a specific mandate. Titles of divisions indicate the main priorities of the Surgeon General’s Office during the war years, and demonstrate that the medical rehabilitation of soldiers was only one among many concerns: the Division of Finance and Supply, the Division of Food and Nutrition, the Hospital Division, the Museum and Library Division, the Division of Gas Defense, and the Board of Publications. The Office also contained various sections centered on medical specialties, including the Dental Division, and the Divisions of Neurology and Psychology, General Surgery, Orthopedic Surgery, and Internal Medicine. On the eve of war, in part because of the growing trend toward medical professional organization and specialization, the Office of the Surgeon General was highly compartmentalized.<sup>58</sup>

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*Department, 1917-1941*, 50. According to the Army Surgeon General’s Annual Report of 1918, there were 123 contract surgeons serving in June 1918, “both male and female.” Annual Report of the Surgeon General to the Secretary of War, 1918, 390. Judith Bellafaire and Mercedes Herrera Graf place the number of women physician volunteers abroad at 76. They also point out that in 1910, 6,000 (or approximately six percent) of the country’s doctors were women. Between 1910 and World War II, they note, the number of women physicians gradually declined: while nursing emerged as a respectable profession, “women doctors remained enigmas, treated by much of society and a significant portion of the medical profession as if they had stepped out of their assigned place.” Graf, *Women Doctors in War* 32.

<sup>57</sup> Byerly, *Fever of War: The Influenza Epidemic in the U.S. Army During World War I*, 25-31. See Chapter Two for a discussion of caregivers other than doctors, including occupational therapists and nurses, who played a crucial role in the rehabilitation effort.

<sup>58</sup> Mary C. Gillett points out that the wartime reorganization of the Army Surgeon General’s office took place in “a curious and often haphazard manner.” As one contemporary observer put it, “it appears that some of the new divisions established in the office of the Surgeon General arose from organizations and men injecting themselves into that office.” Ibid., 20. For a thorough overview of the Medical Department before the war, see Bobby A.

The Hospital Division of the Surgeon General's Office, created in July 1917, was charged with, among other things, devising formulas and methods for increasing domestic bed capacity and obtaining buildings for post, camp, and general hospitals, as well as hospitals geared strictly at treating soldiers who had served overseas. Planning for hospitals for returning troops was, in many ways, the most complex task of the division. Using the experiences of its allies as a guide, the Hospital Division aimed to locate facilities close to soldiers' homes and families, so it estimated the total need for beds within each of 16 regional districts that had been used to organize the military draft.<sup>59</sup>

When the U.S. declared war in April 1917, the medical facilities of the army were decidedly limited. There were 9,530 hospital beds contained in 131 post hospitals, four general hospitals, and five base hospitals. The conditions in at least some of these facilities were sub-par. Following the Civil War, Army Medical Department officials had deemed large field hospitals havens of filth and disease, and advocated for smaller 12-, 24- and 48-bed post hospitals. The latter were severely underfunded, often in ill repair and lacking in such basic sanitary measures as clean drinking water.<sup>60</sup> The number and quality of domestic hospital beds would have to grow exponentially, and very quickly, as the U.S. became more mired in the war effort. Using the experiences of France and Britain as a guide, Army Medical Department officials calculated that enough military hospital beds should exist to cover 3.5 percent of all American Expeditionary

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Wintermute, *Public Health and the U.S. Military: A History of the Army Medical Department, 1818-1917*, *Advances in American History* (New York, New York: Routledge, 2011).

<sup>59</sup> Charles Lynch, *The Medical Department of the United States Army in the World War, Volume 1: The Surgeon General's Office* 330. The report contains a helpful overview of the development of military hospitals in the U.S. between the Colonial era and World War I.

<sup>60</sup> For more on the nature of military hospitals and medicine in the pre-World War I years, see Chapter Two of this dissertation. Mary C. Gillett, *The Army Medical Department, 1865-1917*, *Army Historical Series* (Washington, D.C.: Center of Military History, United States Army, 1995), 51-52.

Forces troops.<sup>61</sup> In 1917 and 1918, Congress appropriated more than \$37.8 million and \$200 million respectively for the construction and repair of hospitals. That was a vast increase over the average annual expenditure of \$400,000 in each of the ten years prior to the war.<sup>62</sup>

Many army officials – like their counterparts on the Council of National Defense, and the architects of the WRIA – were determined not to place enlisted men in civilian institutions, which they felt could be technically and organizationally inferior to those of the military and lacking in disciplinary measures necessary to achieve so-called “curative results.” Also, those facilities were needed to care for civilians, and could hardly be adapted to military needs: they lacked the staff living quarters necessary in an army hospital, and were too small and geographically disbursed to be managed by the military efficiently. As one army report put it soon after the war, “after due consideration, it was decided that the use of civil hospitals for the care and treatment of troops was not feasible because of the uncertainty of the supply of beds, the impracticability of taking over entirely civil hospitals in sufficient number without creating a hardship on the civil population, and the difficulty in operating a military and civil organization in the same institution.”<sup>63</sup>

To meet the increased need for facilities for injured and ill soldiers, the Surgeon General’s Hospital Division planned to utilize military post hospitals and temporarily leased privately-owned land and buildings, and in a few cases, aimed to build entirely new structures; each of these institutions would be under military control. Various War Department divisions had to approve funding and construction plans for each leased or newly purchased facility.

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<sup>61</sup> Frank W. Weed, *Medical Department of the United States Army in the World War; Volume 5: Military Hospitals in the United States*, ed. M.W. Ireland (Washington, D.C.: Government Printing Office, 1923), 25-28.

<sup>62</sup> *Ibid.*, 54, 27.

<sup>63</sup> *Ibid.*, 52-53.

Although the “path from plan to the start of construction remained long and paved with red tape,” by August of 1918, the Hospital Division had successfully made available approximately 95,000 beds at general, port, and base hospitals.<sup>64</sup>

On November 7, 1917, the Office of the Army Surgeon General released an auspicious and all-encompassing “plan for physical reconstruction and vocational training,” meant to serve only as a “tentative outline,” as Surgeon General William Gorgas put it. Physical reconstruction, as Gorgas later defined it, was “the completest (*sic*) form of medical and surgical treatment carried to the point where maximum functional restoration, mental and physical, may be secured.” The ultimate goal was to return the patient to service or civilian life “with the full realization that he can work in his handicapped state, and with habits of industry much encouraged...”<sup>65</sup> The proposed plan stipulated that sick and wounded men who had served abroad would be received at one Staten Island, New York hospital. There, medical officers would individually examine each patient and, if the case warranted further treatment, recommend transfer to a hospital in the patient’s home district. If the doctor believed the individual could not

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<sup>64</sup> The quote is from Gillett, *The Army Medical Department, 1917-1941*, 62-3. By October 1918, 170,000 beds were available. From then on, numbers steadily decreased, reaching just under 30,000 by September 1919. Most temporary military hospitals on leased properties had been abandoned by May 1919. At that point, larger military general hospitals scattered throughout the country were assigned to take on chronic patients who remained in the service. Charles Lynch, *The Medical Department of the United States Army in the World War, Volume 1: The Surgeon General's Office* 338-39. For a detailed overview of the activities of the Hospital Division, see p. 327.

<sup>65</sup> A.G. Crane, *The Medical Department of the United States Army in the World War; Volume 13, Part One: Physical Reconstruction and Vocational Education*, ed. M.W. Ireland (Washington, D.C.: Government Printing Office, 1927), 8. The Surgeon General’s plan was partially based on research findings regarding other countries’ rehabilitation programs. The army, like the Council of National Defense considered the impact of war on populations in France and England. For example, a representative of the Surgeon General’s Office, Joel E. Goldthwait, attended the Inter-Allied Conference for the study of professional re-education in May of 1917, where experts from various nations discussed topics including physical re-education and treatment, the placing and employment of disabled men in civilian life, and the economic and social interests of the disabled. For more information on the conference, see A. Griffith Boscawen, *Report on the Inter-Allied Conference for the Study of Professional Re-Education, and Other Questions of Interest to Soldiers and Sailors Disabled by the War, 8th to 12th May 1917* (London: His Majesty’s Stationery Office, 1917). Also, Douglas Crawford McMurtrie, *A Bibliography of the War Cripple, Series 1, Number 1* (New York: Red Cross Institute for Crippled and Disabled Men, 1918). For more on Goldthwait’s involvement with the war effort, as well as his personal background as an advocate for industrial workers in need of rehabilitation, see Linker, *War’s Waste: Rehabilitation in World War I America*, 52.

benefit from further treatment, or was incapable of resuming his former occupation, a recommendation would be made for his discharge on a surgeon's certificate of disability, which would have to be subsequently approved by a board of three people: one specialist from the soldier's branch of service, an internist, and a vocational officer. If the medical officer believed the soldier had attained the maximum benefit from treatment, but would clearly be unable to resume his previous occupation, he was obliged to supply a report regarding which occupations might be feasible for the patient after training. That report would be reviewed by the vocational officer, who would make employment recommendations of his own, then suggest which general hospital the soldier should be transferred to before moving on to a non-hospital vocational rehabilitation program.<sup>66</sup>

The plan divided the country into 16 districts, which would contain both general and reconstruction hospitals. The latter would be equipped with special physical and occupational therapy curative workshops. The connected "matter of training men in professional lines," the report conceded, "is partially worked out but not completed." Some military hospitals would contain commercial schools that would offer an array of classes, including English, mathematics, salesmanship, advertising, and bookkeeping, among others. In some cases, the government could pay for courses at existing schools while attendees remained under the oversight of army officers. By retaining men in service, the government would ensure that they were "comfortably cared for," and that their training would be expeditiously completed. It would also be following the mandate of Section 302 of the War Risk Insurance Act, which stipulated that as injured soldiers followed rehabilitation courses "as the United States may provide or procure to be provided... a form of enlistment may be required which shall bring the injured person into the

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Crane, *The Medical Department of the United States Army in the World War; Volume 13, Part One: Physical Reconstruction and Vocational Education*, 9-10.



military or naval service.” In the most general sense, Gorgas’ rehabilitation plan was aimed at “making [the wounded soldier], in so far as possible, an independent, wholly self-supporting, self-respecting workman who receives his wage because he earns it and is in no sense an object of charity.” In other words, “the returned soldier’s claim on an opportunity to earn a livelihood is not to be considered a concession to be granted, but rather a right to be recognized.”<sup>67</sup>

The familiar issue of military control was broached in a subsequent Surgeon General’s report meant to clarify the reconstruction plan. It noted the same concern that CND Medical Board meeting attendees had discussed: in England, where vocational training was voluntary, (in other words, completed after soldiers had been discharged from the military), only 15 percent of patients were choosing to complete the courses. The report emphasized that soldiers under military control would be subject to “strict Army discipline.” The soldier simply had to “be made to understand that before he is discharged from the army he is to be functionally restored as far as possible and is to receive proper training that will enable him to overcome his handicap.” According to the report, medical and surgical work, as well as vocational training “rightfully” should be handled by the Surgeon General’s office. But various governmental and private groups were attempting to address the problem, which was “liable to disorganize our whole program.” While the advice of these organizations was valued, according to the Surgeon General, it should be given via an advisory board directly headed by the Secretary of War or the Council of National Defense. Such a hierarchy would help avoid the disorganization evident in England, France, and Canada, where reconstruction work was divided among various different agencies.<sup>68</sup>

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<sup>67</sup> Ibid., 18.

<sup>68</sup> Ibid., 30-31.

Implicit in the Surgeon General's proposed policy was the idea that certain injuries and illnesses were suited to treatment via rehabilitation work while others were not. Originally overseen by the orthopedic department, the reconstruction effort was to focus on soldiers who had sustained recognizable bodily injuries, not those who were diagnosed with less visible maladies, such as mental illnesses. In December 1917, the Secretary of War dictated that the latter group would be eligible for admittance to public institutions focusing specifically on those conditions, including St. Elizabeth's Hospital in Washington, DC or public hospitals in or near their draft districts. In some cases, according to the plan of the Secretary of War, they would follow a distinct course of treatment that focused on cure through therapy and work.<sup>69</sup> As more mentally ill patients were shipped home and hospitals became overwhelmed, the policy was amended.<sup>70</sup>

The Secretary of War and other parties viewed Gorgas' plan as impractically broad and sweeping, but it at least served as a viable alternative for an army already facing major challenges related to the provision of medical care. By the winter of 1917-1918, influenza and pneumonia were threatening domestic camps and the first ill and wounded began arriving from overseas. Reconstruction work thus began in early 1918 at Fort McHenry in Baltimore, Fort McPherson in Georgia, and Walter Reed Army General Hospital in Washington DC. As late as

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<sup>69</sup> "Army Regulations, C.A.R. 61, Changes No. 64", December 13, 1917, 2. Records of the War Department, General and Special Staffs, Correspondence of War College Division and Related Gen. Staff Offices, 1903-1919, Record Group 165, Microfilm 1024, Roll 275, National Archives and Records Administration, College Park, Maryland.

<sup>70</sup> Later chapters of this dissertation will discuss the impact of large numbers of mentally ill soldiers on soldiers' and veterans' hospital systems. For a brief overview of the army's policy toward shell-shocked soldiers for the duration of the war, see Sanders Marble, *Rehabilitating the Wounded: Historical Perspectives on Army Policy*, (Falls Church, VA, July 2008), 17-18. There is a vast literature on shell-shock and combat stress disorders. See, for example, Anthony Babington, *Shell-Shock: A History of the Changing Attitudes to War Neurosis* (Barnsley, United Kingdom 1997). Eric T. Dean, *Shook over Hell: Post-Traumatic Stress, Vietnam, and the Civil War* (Cambridge, Massachusetts: Harvard University Press, 1997). Annessa Stagner, "Healing a Soldier, Restoring the Nation: Representations of Shell Shock in the United States During and after the First World War," *The Journal of Contemporary History* (Forthcoming).

the summer of 1918, the Surgeon General requested that the Secretary of War lend legitimacy to the rules he was passing down to hospital personnel via his own office; he asked that a “general order be issued stating the policy of the War Department in regard to the physical reconstruction of soldiers and including rules for the transfer of such sick soldiers from different camps to special hospitals.”<sup>71</sup> Around the same time, Gorgas also requested that the definition of physical reconstruction – “complete medical and surgical treatment, carried to the point where maximum functional restoration, mental and physical, has been secured...” – be published as a general order.<sup>72</sup>

One challenge precluding the passage of a comprehensive army reconstruction policy was intra-organizational politics. The Surgeon General’s Office, where civilian doctors helped formulate policy, conflicted openly with the Office of the Secretary of War during the early months of war. Doctors affiliated with the Surgeon General’s Office who wished to provide comprehensive health care for injured and ill troops, subscribed to the contemporary notion that the practice of medicine extended to therapy and cure, and could help create productive citizens. But their values did not jibe with the institutional norms of the military. Indeed, there was a cognitive dissonance between the strict tenets of military medicine, which placed the army’s mission above individual patients’ well-being, and the common rhetoric surrounding soldiers and veterans, which assumed that those who made bodily sacrifices during service should enjoy access to special rights and privileges.

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<sup>71</sup> "Memorandum for the Chief of Staff from Lytle Brown, Brigadier General, Director, War Plans Division, Re. Request of Promulgation of General Order ", July 2, 1918. Records of the War Department, General and Special Staffs, Correspondence of War College Division and Related Gen. Staff Offices, 1903-1919, Record Group 165, Microfilm 1024, Roll 346, National Archives and Records Administration, College Park, Maryland.

<sup>72</sup> "Memorandum to the Chief of Staff from Surgeon General William C. Gorgas, Re. Request of Promulgation of a General Order", June 24, 1918. Records of the War Department, General and Special Staffs, Correspondence of War College Division and Related Gen. Staff Offices, 1903-1919, Record Group 165, Microfilm 1024, Roll 346, National Archives and Records Administration, College Park, Maryland.

In late 1917, great tension was developing between medical officers and their army colleagues. A high-ranking army doctor recalled soon after the war that there was a lack of regard on the part of the Secretary of War for the necessities of running a successful rehabilitation program. "Memoranda requesting approval of needed hospital construction, equipment for physiotherapy, for occupational therapy and for a qualified personnel," he reported, "were disapproved wholly or in part or were returned for additional information from the General Staff."<sup>73</sup> As a case in point, during Congressional hearings about pneumonia outbreaks at training camps throughout the country during the winter of 1918, the two cohorts exchanged accusations. Surgeon General Gorgas argued that mass illness and unsatisfactory conditions at camps could be explained by the fact that his superior officers had been non-responsive to Medical Department requests for more clothing, space, and medical staff. Secretary of War Newton D. Baker rejected such claims. Individual medical officers, he said, were to blame. He went so far as to court martial two doctors for the deaths of recruits from pneumonia, thus absolving himself and his line command of any responsibility. The exchange, according to historian Carol Byerly, signified strong tensions between the two departments that remained throughout the war.<sup>74</sup> Secretary of War Baker's eventual approval of Gorgas' request that a reconstruction policy be formulated can be seen as a tacit acknowledgement that a more unified, structured system was necessary. Baker was also likely moved to act by the public interest (and publicity) surrounding the health and welfare of a newly assembled majority conscript army.

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<sup>73</sup> Colonel Frank Billings, "Modern Military and Surgical Reconstruction and the Measures of Cooperation Practiced by the Medical Department of the Army and the Federal Board for Vocational Education," *The Military Surgeon* Vol. XLVII, no. Number 1 (July 1920): 2.

<sup>74</sup> Byerly, *Fever of War: The Influenza Epidemic in the U.S. Army During World War I*, 40-42. The above account is based on Byerly's comprehensive discussion of the hearings and dispute.

The 1918 hearings hinted at the fact that army officials were not only faced with the task of planning for the medical treatment of severely injured troops via a comprehensive, long-term rehabilitation policy, but that they also needed to address the more immediate concern of how to treat troops who were found to be ill before fulfilling many of the duties for which they were recruited. Under what conditions, the Secretary of War had to decide, could such soldiers be sent to the front? In March 1918, Baker ordered that “no officer or man who is physically unable to perform full military duty will be permitted to accompany his organization to France unless it is believed by the medical officers... that he will be able to perform full duty within two weeks from date of departure.” Others, the Secretary of War said, would be transferred to depot brigades, or U.S.-based organizations.<sup>75</sup> In the months immediately following the war, congressional representatives were disturbed to find that some of these very same troops – those who were recruited by the army, but were unable to serve for an extended period, or in full capacity because of a supposed physical or mental inability – were nonetheless eligible for state-sponsored military and veterans’ medical care.<sup>76</sup>

Perhaps the most sweeping challenge to the uniform implementation of an army rehabilitation policy was the pervasive question of the extent to which the military and its medical personnel should oversee rehabilitation work. In other words, where did military responsibility end, and civilian responsibility begin? When did a wounded soldier become a rehabilitating veteran?

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<sup>75</sup> "Memorandum for the Adjutant General of the Army from William S. Graves, Brigadier General, National Army, Assistant to the Chief of Staff", March 7, 1918. Records of the War Department, General and Special Staffs, Correspondence of War College Division and Related Gen. Staff Offices, 1903-1919, Record Group 165, Microfilm 1024, Roll 346, National Archives and Records Administration, College Park, Maryland.

<sup>76</sup> A great majority of those eventually discharged due to disability never left the U.S. See Chapter Two for a further discussion of this issue.

Early in the war effort, the Army Surgeon General's office demonstrated its willingness to take an active role in all aspects of rehabilitation and after-care – beyond the expansion of hospitals and the provision of strictly medical therapies. In the summer of 1917, approximately four months after the U.S. declared war, Medical Department Lieutenant Colonel Theodore Lyster recommended that Army Surgeon General Gorgas appoint one person to spearhead efforts surrounding “reconstruction, reeducation, and aftercare of disabled soldiers.”<sup>77</sup> Gorgas heeded Lyster's call by establishing in August 1917 a Department of Physical Reconstruction (DPR) within the army.

He chose as its head physician Frank Billings, who was deemed one of the “foremost medical men of the country” when he first accepted a commission in 1908, along with some of his more prominent colleagues, to the newly established Army Medical Reserve Corps.<sup>78</sup> Billings received his medical degree from Northwestern University in 1881 and underwent subsequent training in Vienna, Paris, and London, then served as an attending physician at various Chicago hospitals between 1890 and 1920. Credited with helping to shape medical education standards, he served as Dean of Rush Medical College, and president of the American Medical Association, the Association of American Physicians, the National Association for the Study and Prevention of Tuberculosis and later, the Institute of Medicine.<sup>79</sup> Billings and other prominent civilian doctors who worked with the Army Medical Corps during the war saw their work with the

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<sup>77</sup> Crane, *The Medical Department of the United States Army in the World War; Volume 13, Part One: Physical Reconstruction and Vocational Education*, 3.

<sup>78</sup> "Noted Doctors Join Medical Corps," *The New York Times* November 30, 1908. The Army Medical Reserve Corps was established, in large part, as a result of the disorganization surrounding mobilization for the Spanish-American War. For a brief summary, see Charles Lynch, *The Medical Department of the United States Army in the World War, Volume 1: The Surgeon General's Office* 58.

<sup>79</sup> Edwin Frederick Hirsch, *Frank Billings: The Architect of Medical Education, an Apostle of Excellence in Clinical Practice, a Leader in Chicago Medicine* (Chicago, Illinois: University of Chicago Press, 1966).

military as both a patriotic duty, and highly relevant to the civilian medical world. Billings pointed out that tactics used in the treatment of soldiers could be applied to victims of industrial accidents. “One may not contemplate the physical and mental rehabilitation of disabled soldiers,” he wrote in 1919, “without a consideration of the past and present neglect of the disabled men in the great industrial armies of the world.” General rehabilitation principles, Billings argued, “should be the same as that applied in military organizations, but the program should be modified to meet civilian demands and conditions.”<sup>80</sup>

Billings’ Division of Physical Reconstruction cooperated with the Surgeon General’s Hospital Division, as well as clinical divisions such as General Surgery and Neuropsychiatry, but had a general mission that was, at the outset, “not well defined” and occasionally controversial.<sup>81</sup> Surgeon General Gorgas instructed his new department head to “take immediate steps to coordinate all activities of both military and civilian interests relating to physical reconstruction.”<sup>82</sup> In other words, the DPR was to ensure that disabled and ill soldiers received the therapies and vocational training necessary to become self-supporting civilians.

It was a daunting assignment. Various parties had a stake in the nature of the DPR’s plans. Civilian educators hoped ex-soldiers would receive vocational training outside of military institutions, and that a wartime reconstruction plan would pave the way toward a federal mandate for the training of injured civilian industrial workers. But Billings was a standard-bearer for the other major group with an interest in the nature of the DPR’s plans: Army Medical Department

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<sup>80</sup> Frank Billings, “Rehabilitation of the Disabled,” in *Contributions to Medical and Biological Research, Volume 2* ed. Thomas Clifford Allbutt Sir William Osler, Charles Loomis Dana (New York: Paul B. Hoeber, 1919).

<sup>81</sup> Charles Lynch, *The Medical Department of the United States Army in the World War, Volume 1: The Surgeon General’s Office* 474.

<sup>82</sup> Crane, *The Medical Department of the United States Army in the World War; Volume 13, Part One: Physical Reconstruction and Vocational Education*, 5.

doctors, who in 1917 and 1918, provided treatment for the first American casualties of war. The great majority of those medical practitioners were civilians who had joined the army temporarily, and they felt strongly that efficiency would be increased and attrition rates decreased if soldiers remained in military hospitals – and under the supervision of medical, as opposed to educational professionals – for the duration of their rehabilitation.<sup>83</sup>

Secretary of War Baker likely had some of these issues in mind when he suggested that the Surgeon General call a conference in January 1918 between representatives from his office as well as 13 other organizations, including the Council of National Defense, the American Red Cross, the Bureau of War Risk Insurance, the Department of Labor, the Public Health Service, and the Federal Board for Vocational Rehabilitation (FBVE). These were the primary players in rehabilitation and related efforts, and the intention of the conference was to ensure coordination and cooperation. Gorgas appointed a committee of 14 – one representative from each group – to draw up a program for soldiers' rehabilitation, and named not a military official, but a representative from the United States Bureau of Education as its head. The Committee came to the conclusion that the Surgeon General – and by extension the DPR – should oversee medical and surgical work necessary for “functional and mental restoration” of service members. But once troops “had reached as complete a state of physical and mental rehabilitation as possible,” they should be discharged and placed “under the control” of another government agency that would oversee vocational education.<sup>84</sup>

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<sup>83</sup> For a detailed account of the doctor-educator rift, and Congressional debates between the two parties, see Linker, *War's Waste: Rehabilitation in World War I America*, 154-65.

<sup>84</sup> Crane, *The Medical Department of the United States Army in the World War; Volume 13, Part One: Physical Reconstruction and Vocational Education*, 36.



As Beth Linker notes, civilian vocational educators debated – sometimes contentiously – with army doctors throughout the winter of 1917 and 1918 regarding how best to pursue the common goal of returning disabled and ill soldiers to productive citizenship. The educators argued that they should oversee all after-care, since vocational education promoted independence, while continued medical treatment and long-term hospitalization promoted the opposite. DPR head Frank Billings and other volunteer army doctors took issue with the portrayal of medicine as such a limited field, and with civilian educators’ depictions of them as “martinets” blindly attempting to keep all rehabilitation efforts under the control of the military. The army was the only entity, they pointed out, actually providing care for disabled soldiers while other organizations merely passed judgment.<sup>85</sup>

Eventually, the vocational educators’ arguments won the day. In April 1918, the army dictated that the Federal Board for Vocational Education – which had been created approximately a year earlier to provide aid to state vocational schools training conscripts – would oversee the vocational education aspect of rehabilitation.<sup>86</sup> Legislative approval came in July 1918, with the Smith-Sears Act, which appropriated \$200 million for the rehabilitation of disabled veterans, and placed the FBVE in charge of oversight.

Throughout the spring of 1918, as it became clear that the FBVE would gain control of vocational education efforts, some army officials questioned the Surgeon General’s proposed reconstruction policy, wondering where “medical reconstruction” (the province of the Army

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<sup>85</sup> The representation of the ideas of work and productivity in rehabilitation literature and practice will be discussed in Chapters Two and Three of this dissertation. The quote is from Beth Linker, "For Life and Limb: The Reconstruction of a Nation and Its Disabled Soldiers in World War I America" (PhD, Yale University, 2006), 184.

<sup>86</sup> "Memorandum for the Chief of Staff Regarding Reconstruction and Rehabilitation of Officers and Enlisted Men, from E.D. Anderson, Colonel, General Staff, Chairman, Equipment Branch", April 30, 1918. Records of the War Department, General and Special Staffs, Correspondence of War College Division and Related Gen. Staff Offices, 1903-1919, Record Group 165, Microfilm 1024, Roll 346, National Archives and Records Administration, College Park, Maryland.

Medical Department) ended, and “physical and mental rehabilitation” (which the FBVE was to oversee), began.<sup>87</sup> According to the originally proposed reconstruction plan, noted Colonel E.D. Anderson, Chairman of the army’s Equipment Branch, it was unclear “where the Surgeon General intends to draw this line of distinction.” Anderson took issue with the Surgeon General’s stipulation that prior to discharge, “work, mental and manual” should be used to ensure that “maximum functional restoration, mental and physical has been secured.” Such an order, he argued, conflicted with the province of the FBVE.<sup>88</sup>

Once the FBVE was officially placed in charge of vocational rehabilitation for veterans in July 1918 via the Smith-Sears Act, representatives of the Surgeon General’s Office also expressed worry that discharged soldiers would not, of their own volition, apply for aid or obtain the help they needed. “Disheartened men,” one official said, would not pursue such an opportunity.<sup>89</sup> It was imperative, these army rehabilitation advocates argued, to at least begin practical rehabilitation work while soldiers were still enlisted.

To these ends, Col. James E. Russell, Dean of the Teachers’ College of Columbia University, was appointed director of the Education Section of the Department of Physical Reconstruction. His efforts were guided by the belief that “mental depression and indisposition to respond to medical and surgical treatment on the part of the wounded men covered [by the

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<sup>87</sup> "Memorandum for the Adjutant General of the Army Regarding Reconstruction and Rehabilitation of Officers and Enlisted Men from Henry Jervey, Brigadier General, Acting Assistant, Chief of Staff, Director of Operations", April 1918. Records of the War Department, General and Special Staffs, Correspondence of War College Division and Related Gen. Staff Offices, 1903-1919, Record Group 165, Microfilm 1024, Roll 346, National Archives and Records Administration, College Park, Maryland.

<sup>88</sup> "Memorandum for the Chief of Staff Regarding Reconstruction and Rehabilitation of Officers and Enlisted Men, from E.D. Anderson, Colonel, General Staff, Chairman, Equipment Branch".

<sup>89</sup> "Memorandum for the Chief of Staff, Regarding Physical Reconstruction, from Lytle Brown, Brigadier General, Director, War Plans Division", July 20, 1918. Records of the War Department, General and Special Staffs, Correspondence of War College Division and Related Gen. Staff Offices, 1903-1919, Record Group 165, Microfilm 1024, Roll 346, National Archives and Records Administration, College Park, Maryland.

Smith-Sears Act] is particularly active owing to the seriousness of their injuries and the consequent lack of hope of being of future use to the community.” Russell suggested that “cheer-up” work begin in army hospitals, in the form of “real education,” to help lay the groundwork for later work by the FBVE.<sup>90</sup> In formal outlines of the work to be completed by the Education Section, submitted in the spring and summer of 1918, Russell defined “real education” in broad terms, encompassing everything from musical entertainment, handiwork, lectures, sports, elementary classes for those who were illiterate, and technical and academic classes in subjects such as drawing, applied science, and agricultural work. In large army general hospitals, plans of the education division guided occupational therapy and recreational programs, and constituted a major thrust of the army’s attempt to ready soldiers for civilian life.<sup>91</sup>

Secretary of War Baker finally approved a comprehensive reconstruction plan from the Surgeon General on August 1, 1918 – 16 months after the United States declared war and approximately three months before the Armistice. It stated that there were three types of cases to be treated in military hospitals: those able to return to full military duty, those fit for limited service, and those eligible for discharge due to disability. Fifteen hospitals across the country were designated as reconstruction hospitals, where the Surgeon General’s recommended discharge policy would be in effect: that “no member of the military service disabled in line of duty, even though not expected to return to duty, will be discharged from service until he shall have attained complete recovery or as complete recovery as may be expected when the nature of

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<sup>90</sup> "Memorandum for the Chief of Staff Regarding Organization of a Department of Education in the Medical Corps, from Lytle Brown, Brigadier General, Director, War Plans Division", July 1918. Records of the War Department, General and Special Staffs, Correspondence of War College Division and Related Gen. Staff Offices, 1903-1919, Record Group 165, Microfilm 1024, Roll 346, National Archives and Records Administration, College Park, Maryland.

<sup>91</sup> Crane, *The Medical Department of the United States Army in the World War; Volume 13, Part One: Physical Reconstruction and Vocational Education*, 45-51.

his disability is considered.” The policy further stipulated that, “modern medical treatment does not end with medical cure.” Although soldiers who would be able to return to duty constituted the highest priority in military hospitals, those who might serve in a limited capacity or be discharged due to disability, the plan said, should “have, while in the hospital, such physical training and general education as will best promote their physical reconstruction.”<sup>92</sup> A few months prior to signing the rehabilitation plan, Baker had approved the Surgeon General’s request to organize 15 hospitals “to receive cases requiring special physical reconstruction treatment,” as well as the request that the Surgeon General’s office be authorized to prepare special regulations (subject to approval by the War Department) for physical reconstruction.<sup>93</sup>

In spite of their shapers’ best intentions and attempts to be pro-active, the army’s policies were, in many ways, too slow in coming. The number of soldier-patients in army general hospitals had increased dramatically during the year the Secretary of War and Army Surgeon General debated about a reconstruction policy. For example, at Walter Reed Army General Hospital, approximately 4,300 patients were admitted in 1917; during 1918, the hospital admitted more than 14,435.<sup>94</sup> Thousands of patients were thus treated before a comprehensive policy existed regarding their after-care.

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<sup>92</sup> Ibid., 41-43.

<sup>93</sup> "Memorandum for the Adjutant General Regarding Physical Reconstruction, from War Department Chief of Staff", February 1918. Records of the War Department, General and Special Staffs, Correspondence of War College Division and Related Gen. Staff Offices, 1903-1919, Record Group 165, Microfilm 1024, Roll 346, National Archives and Records Administration, College Park, Maryland.

<sup>94</sup> "Walter Reed Army General Hospital Annual Report for 1918", January 30, 1919. Records of the Office of the Surgeon General, RG 112, Box 1, Entry 401, Folder: Annual Report 1918, National Archives and Records Administration, Washington, D.C. "Walter Reed Army General Hospital Annual Report for 1917", May 2, 1918. Records of the Office of the Surgeon General, RG 112, Box 1, Entry 401, Folder: Annual Report 1917, National Archives and Records Administration, Washington, D.C. Walter Reed’s war-time activities will be discussed in Chapter Two.

Within three and a half months of the passage of the reconstruction plan, the Armistice brought about new questions. As one scholar writes, “the quick advent of peace before half the army could even reach Europe proved a mixed blessing for the some 334,000 men then in army hospitals and those who would later come down with tuberculosis or shell shock.”<sup>95</sup> Although reconstruction hospitals in the U.S. did not see peak populations until March 1919, the Armistice came in November 1918.<sup>96</sup> Thus, the mindset of the government and public shifted toward peace, even before many soldiers made their way back from abroad. And funding for army programs was increasingly harder fought as the war became, in the minds of many, an increasingly distant memory. Once the end of the war came, many approved reconstruction hospital projects were abandoned, and the army relied on expanded base and general hospitals.<sup>97</sup> Timing, in some ways, helps to explain the confusion and redundancies experienced by soldiers, administrators, and medical professionals during much of the war.

As government entities struggled to decipher areas of jurisdiction, an array of volunteer organizations played central roles at large army hospitals. Walter Reed Army General Hospital’s campus, for example, housed branches of agencies such as the American Red Cross, the Young Men’s Christian Association, the Jewish Welfare Board, and the Knights of Columbus. Hospitals offered rare opportunities for the organizations: “When men are sick and lonely they are most susceptible to kindness,” one YMCA training manual said. “The atmosphere of hurry and bustle

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<sup>95</sup> William Pencak, *For God and Country: The American Legion 1919-1941* (Boston: Northeastern University Press, 1989), 177.

<sup>96</sup> Data regarding numbers treated are contained in: Additional Hospital Facilities for Discharged Soldiers, Sailors, Marines, and Army and Navy Nurses, House Document No. 481, Sixty-Sixth Congress, Second Session, (Washington, D.C.: Government Printing Office, December 8, 1919). For more on peak hospital populations, see Chapter Four.

<sup>97</sup> Gillett, *The Army Medical Department, 1917-1941*, 440.

is absent and there is ample time to think.”<sup>98</sup> In a complex partnership with the army and government, these organizations assisted greatly in rehabilitation efforts. They provided patient-troops with options for disciplined leisure, arranging baseball games, movie viewings, dances, and other activities. As such, they played an integral role in the army’s attempts to foster a sense of socialization, normalcy, and contentment among wounded and ill service members. As one army report put it, the involvement of these “associated societies and corporations” demonstrated “the universal interest in the people in the support and protection of the armies of the country...”<sup>99</sup>

Perhaps no civilian organization was more integral to efforts surrounding soldiers’ rehabilitation than the American Red Cross. During World War I, its staff – paid and volunteer – pursued the organization’s founding mission “to act in matters of voluntary relief and in accordance with the military authorities as a medium of communication between the people of the United States and the armed forces of the United States.”<sup>100</sup> The Red Cross spearheaded a wide array of aid efforts, from providing supplies, canteens, ambulance companies, and base hospitals, to operating information offices and supplying nurses at military hospitals both abroad and in the U.S. During the war, 8.1 million workers served in the organization, of whom 23,822 were nurses.<sup>101</sup> The American Red Cross was a primary vehicle through which civilians could

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<sup>98</sup> The National War Work Council of the Young Men's Christian Association of the United States, "Manual of Camp Work for Army and Navy Young Men's Christian Associations, Fifth Edition" 1918. See "Morale Support" Finding Aid, Army Heritage and Education Center, Carlisle, Pennsylvania.

<sup>99</sup> Annual Report of the Surgeon General of the Public Health Service of the United States for the Fiscal Year 1918, (Washington, D.C.: Government Printing Office, 1918), 15.

<sup>100</sup> "Congressional Charter of the American Red Cross," <http://www.redcross.org/www-files/Documents/Governance/charter.pdf>.

<sup>101</sup> "The Work of the American Red Cross During the War, a Statement of Finances and Accomplishments for the Period July 1, 1917-Feb. 28, 1919". American Red Cross, Army Heritage and Education Center, Carlisle, Pennsylvania.

demonstrate support for those who served. On May 1, 1917, there were approximately 496,000 members spread among 562 chapters. By February 28, 1919, thanks to wartime campaigns for support, membership had ballooned to approximately 20 million adults and 11 million children in 3,724 chapters. Wartime funding drives in June 1917 and May 1918 helped bring in a total collection of more than \$169.5 million to devote to relief work. Almost a quarter of those funds (approximately \$38 million) were devoted to providing services at hospitals in the U.S. There, the Red Cross supplied stationery, stamps, telegrams, entertainment, and in some cases, staff and convalescent centers. The organization also helped hospitalized soldiers and sailors who were “worried about their home affairs” establish communication with their families, in some cases providing loans so they could visit loved ones.<sup>102</sup>

As the case of the Red Cross makes clear, medical professionals, the government and army were not the only entities attempting to devise policies for the care of the war-wounded. In fact, the attempt by volunteer organizations to provide comprehensive services likely served to raise expectations of health services among soldiers, their families, and the general public, and contributed to veterans’ demands for better after-care.

*Policy limitations and questions: Discharge and “line of duty” injuries*

Two complex questions pervaded debates about reconstruction policies before, during, and after the war, and would play an integral role in the shape of the military and veterans’ hospital systems for many years to come. First, when was it proper for the army to discharge a wounded or ill soldier? After all, individual soldiers and doctors had different expectations of

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<sup>102</sup> Ibid. For a concise description of efforts of the American Red Cross to assist the Army Medical Department early in the war, see Gillett, *The Army Medical Department, 1917-1941*, 7-8.

what constituted “complete recovery,” and varying beliefs regarding how to judge whether “further treatment” would lead to improvement. Second, what constituted a “line of duty” injury?

Army officials continually re-evaluated the question of when the military ceased being responsible for wounded and ill soldiers, repeatedly amending policies regarding discharge even after the Armistice. In January 1918, Col. D.W. Ketcham of the Army General Staff drafted a memo to the Secretary of War requesting the re-consideration of December 1917 War Department regulations, which had stipulated that “when an enlisted man becomes unfitted for military service, a certificate of disability for discharge will be prepared by the soldier’s immediate commanding officer and forwarded.” Ketcham suggested that the policy be broadened. Echoing a recommendation of the Surgeon General, he argued that no soldier should be discharged “until he has attained complete recovery or as complete recovery as it is to be expected that he will attain when the nature of his disability is considered.” Ketcham justified the policy based on the fact that “it would be most unfair” to release from service “physically unfit soldiers.” Reminiscent of the sentiments of the drafters of the War Risk Insurance Act, Ketcham noted that volunteer and drafted soldiers deserved assurance “in case they are incapacitated through injury or disease, that they will be clothed, housed, fed, and given medical treatment until as complete a cure as it is possible to attain has been effected.” Retaining such soldiers in the army also alleviated the possibility that they would become “an unnecessary and unjust burden” on their relatives and communities.<sup>103</sup>

In February of 1918, Secretary of War Newton D. Baker approved the Surgeon General’s recommended discharge policy, amending Paragraph 159 of Army Regulations to read: “When

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<sup>103</sup> "Memorandum for the Chief of Staff Regarding Physical Reconstruction, from D.W. Ketcham, Colonel, General Staff", undated, c. January 1918. Records of the War Department, General and Special Staffs, Correspondence of War College Division and Related Gen. Staff Offices, 1903-1919, Record Group 165, Microfilm 1024, Roll 346, National Archives and Records Administration, College Park, Maryland.



an enlisted man becomes unfitted for military service, full or partial duty, because of wounds or disease contracted in line of duty, he will not be discharged until he has attained as complete recovery as is to be expected when the nature of his disability is considered.” A certificate of disability and discharge would be prepared, the new regulation said, only “when it is believed that further treatment will not improve his condition.”<sup>104</sup>

Army officials pondered a litany of new discharge regulations in the winter of 1918-1919, as a massive influx of sick and wounded troops flooded into domestic army hospitals, and as doctors and patients expressed an increasing eagerness to be released from service. In order to avoid the possibility that previous orders “unduly retard the discharge from the service of men clearly unfit for military service,” Henry Jervey, Assistant Chief of Staff in the Office of the Secretary of War, offered various clarifications to War Department policies. Cases that would not benefit from “further sojourn” in hospitals, convalescent centers or development battalions, Jervey noted, “should be promptly discharged.” Utilizing an iteration of the relatively vague terminology contained in the army reconstruction plan, Jervey added that only the surgeon overseeing a particular case could “judge whether or not maximum restoration has been secured.” Soldiers who had “funds or who have relatives or friends in position to afford them specialized care” could be discharged once a commanding officer determined that “care is assured.”<sup>105</sup> The new rules further provided that all soldiers who had “acquired a lower physical

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<sup>104</sup> "Memorandum for the Adjutant General Regarding Physical Reconstruction, from War Department Chief of Staff", February 1918.

<sup>105</sup> "Memorandum for the Adjutant General Regarding Discharge of Disabled Soldiers, from Henry Jervey, Major General, Assistant Chief of Staff, Director of Operations", December 17, 1918. Records of the War Department, General and Special Staffs, Correspondence of War College Division and Related Gen. Staff Offices, 1903-1919, Record Group 165, Microfilm 1024, Roll 346, National Archives and Records Administration, College Park, Maryland. On December 31, 1918 the War Department approved a policy to release disabled soldiers from service who applied to be discharged, if they furnished documents from relatives or friends which guaranteed the necessary specialist treatment after discharge, and if they released the War Department from further responsibility for their treatment. See Crane, *The Medical Department of the United States Army in the World War; Volume 13, Part One:*

standard than that given them when they entered the service,” should be discharged once it was determined that “maximum improvement has been obtained or that physical disabilities have not been exaggerated or accentuated as a result of service in line of duty.” Those whose maladies were aggravated by service were to be sent to convalescent centers, “providing further benefit can be expected by additional treatment, training and hardening processes.”<sup>106</sup>

The constantly changing discharge rules begged another question: how could army doctors assess whether an illness or injury was incurred in the line of duty? Would soldiers be treated by the Army Medical Department in military hospitals for illnesses that arose, but likely did not originate, during their time in service, or would they be immediately discharged?

Tuberculosis among new recruits was an especially vexing problem that, between the fall of 1917 and the spring of 1918, prompted a re-thinking of army rationale regarding the definition of the term “line-of-duty.” In September 1917, Surgeon General Gorgas issued a circular stipulating that chronic tuberculosis would be considered to have existed prior to service if the ill soldier had been enlisted for less than three months, unless “exposure in line of duty” led to the condition.<sup>107</sup> Eight months later, in April 1918, the Surgeon General’s office recommended that its own policy be overturned since it had led to “considerable injustice.” There was a “lack of uniformity” in how doctors judged whether or not cases of TB could be connected to service. For this reason, the Surgeon General suggested a new blanket policy that “any soldier who shall have

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*Physical Reconstruction and Vocational Education*, 49. Those who requested “waivers” were eventually made eligible for care as veterans. For more on this policy, see Chapter Three.

<sup>106</sup> “Memorandum for the Adjutant General Regarding Discharge of Disabled Soldiers, from Henry Jervay, Major General, Assistant Chief of Staff, Director of Operations” December 17, 1918, 2.

<sup>107</sup> “Memorandum for the Chief of Staff Regarding Physical Disability in Line of Duty, from D.W. Ketcham, Colonel, General Staff”, April 17, 1917. Records of the War Department, General and Special Staffs, Correspondence of War College Division and Related Gen. Staff Offices, 1903-1919, Record Group 165, Microfilm 1024, Roll 275, National Archives and Records Administration, College Park, Maryland.

been accepted on his first physical examination (after arrival at a military station) as fit for service, shall be considered to have contracted any subsequently determined physical disability in the line of duty.” The Secretary of War approved the Surgeon General’s request, and established that soldiers could be treated in military hospitals for tuberculosis, and by extension, other illnesses, even if they existed prior to service.<sup>108</sup> There was some room for judgment on the part of individual doctors: if it could be shown that the illness was “the result of (a soldier’s) own carelessness, misconduct, or vicious habits,” or that “the history of the case shows unmistakably that the disability existed prior to entrance into the service,” physicians could list the disease as having occurred not in the line of duty. The relatively lenient policy made perfect sense, given the fact that, before and during the war, the army was attempting to retain as many people as possible.

But in the near future, questions would arise regarding the extent of the government’s responsibility for treatment of veterans who disputed medical boards’ judgments that their maladies did not originate in the line of duty. In March 1919, then Army Surgeon General Merritte W. Ireland noted that although Section 302 of the War Risk Insurance Act stipulated that the Bureau of War Risk Insurance must provide medical and hospital care “for former soldiers suffering from disabilities incurred in the line of duty,” it was “not empowered by that or any other law known to this office to provide medical and hospital care for former soldiers suffering from disabilities which did not originate in the line of duty [emphasis in the original].” He explained:

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<sup>108</sup> Ibid. Carol R. Byerly provides a detailed account of changing discharge policies surrounding tuberculosis in this period, and, more broadly, insight on the Army’s handling of the disease during the Great War. Carol R. Byerly, *Good Tuberculosis Men: The Army Medical Department's Struggle with Tuberculosis* (Washington, D.C.: Borden Institute, Forthcoming).

The view may possibly be entertained by some that the government owes no obligation to men suffering such disabilities, and that is probably true so far as the disabilities themselves are concerned, but it does to my mind owe the obligation of benevolence at least to the men who were exposed to the hazards of the military service, thus depriving them for the time being of their private control over their own lives and denying them the opportunities perhaps of accumulating competency. I think this is especially true in the case of defects which may be wholly or measurably remedied by surgical operations... the cure of these defects would be not merely a private benefit or advantage to the men but would also be a service of measurable value to the community.

Ireland concluded that, "because of the service which such men rendered, it would be a matter of well deserved grace for the government to make provision for the medical and hospital care not by way of indemnity for damage suffered by them in the public cause but by way of gratitude for the services rendered." Congress, he said, should authorize the admission of such patients to army hospitals for treatment within 90 days of their discharge.<sup>109</sup>

Brigadier General Lytle Brown, Director of the army's War Plans Division, took issue with the leniency of the Surgeon General's suggested policy, and helped convince the Secretary of War to reject it. Brown noted, "a soldier has ample opportunity before his discharge in the great majority of cases for obtaining medical treatment... if he does not desire to take advantage of the opportunities afforded him, it is his own fault and not any fault of the War Department."<sup>110</sup> Chief of Staff Peyton C. March, concurred, adding that Ireland's policy inadvertently favored those discharged in the later stages of mobilization because of its stipulation that a soldier must seek treatment within 90 days of his discharge. More importantly, it allowed for extended treatment for "soldiers whose disabilities... may, in fact, have been the result of their own willful

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<sup>109</sup> Ireland is quoted in "Memorandum for the Chief of Staff Regarding Medical Care of Former Soldiers, from Lytle Brown, Brigadier General, General Staff, Director, War Plans Division", March 17, 1919. Records of the War Department, General and Special Staffs, Correspondence of War College Division and Related Gen. Staff Offices, 1903-1919, Record Group 165, Microfilm 1024, Roll 346, National Archives and Records Administration, College Park, Maryland.

<sup>110</sup> "Memorandum for the Chief of Staff Regarding Medical Care of Former Soldiers, from Lytle Brown, Brigadier General, General Staff, Director, War Plans Division", March 17, 1919.

misconduct.” Finally, March declared: “such soldiers are sufficiently provided for under the present policy of not discharging them until their disabilities have been corrected in so far as possible.”<sup>111</sup>

Debates surrounding definitions of “line of duty” and the proper limitations of the purview of the Army Medical Department hinted at the variety of policy and administrative challenges that emerged as disabled and ill soldiers of the First World War were treated by the Army Medical Department, and subsequently became a societal responsibility. As the government struggled to fulfill its pre-war promise of providing medical care for former troops, attempts to arrive upon mutually agreeable policies, and coordinate the services of multiple federal agencies brought about conflicts regarding jurisdiction and led to shortfalls in care.

### Conclusion

The War Risk Insurance Act, Council of National Defense, and army plans for reconstruction reflect important characteristics of their time. The War Risk Insurance Act encapsulated Progressive Era ideals regarding the balance between efficiency, individual and familial responsibility, and governmental obligations to citizens. The existence and discussions of the CND Medical Board demonstrated the strengthening of the notion that the U.S. state was composed of a delicate balance between public and private interests. The army’s reconstruction plans made it clear that the United States military was no longer a locally based fighting force, but instead, a culturally shaped institution with an expanding social and professional agenda.

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<sup>111</sup> "Memorandum for the Chief of Staff, Regarding Medical Care of Former Soldiers, from Lytle Brown, Brigadier General, Director, War Plans Division", April 3, 1919. Records of the War Department, General and Special Staffs, Correspondence of War College Division and Related Gen. Staff Offices, 1903-1919, Record Group 165, Microfilm 1024, Roll 346, National Archives and Records Administration, College Park, Maryland.

When the three are examined in concert, it becomes clear that the government perceived a need for long-term medical care for veterans, but failed to formulate feasible plans for its institutionalization. A variety of factors – the determination to create a self-sufficient veteran class prime among them – led the framers of the War Risk Insurance Act and others to the conclusion that the army should be in charge of rehabilitation efforts. There was thus a lack of planning for future medical needs of veterans in the civilian sector. At the same time, there were delays in the passage of a wide-ranging army rehabilitation plan and a related lack of clarity regarding discharge rules and which government agency would control after-care. While the army was the entity most proactively and comprehensively planning for the treatment of service members, it was also the one least able to sustain it, seeing as chronically ill and severely injured troops – and many of the doctors who had signed on to treat them – would not remain enlisted. Even as army officials accepted the responsibility of caring for soldiers until they were “maximally cured,” what that term meant, and what would happen to military personnel after discharge, was largely unknown. The short sightedness of these pre-war policies created a space for the mass expansion of services in the post-war years.

Before being discharged from the army into a somewhat confusing organizational catacomb, thousands of ill and injured soldiers adapted to their health circumstances in domestic military institutions such as Walter Reed Army General Hospital in Washington, DC. The relative brevity of U.S. involvement in the war meant that the army rehabilitation program was nascent even as the country demobilized. Nonetheless, throughout early 1918, the Army Medical Department eagerly built reconstruction programs at various U.S. hospitals. Those facilities had multi-faceted and complicated missions that extended well beyond medical treatment.

## CHAPTER TWO

### **“Take your place and carry on”: Occupational therapy and rehabilitation at the new Walter Reed Army General Hospital (1918-1919)<sup>1</sup>**

When Lena Hitchcock was assigned to Walter Reed General Hospital in early 1918 as one of the United States Army’s first occupational therapists, she was determined to “prove (her) courage and achieve heroic deeds.” Hitchcock found herself snubbed, however, by patients, army doctors, and nurses alike. Doctors were “furious that we had been foisted upon them,” she later reported. Ill and wounded soldiers recently home from France “were bitter and disgruntled... they continually, but unsuccessfully, tried to bait me into unbecoming retorts.” Furthermore, Hitchcock noted, “The nurse in charge was as unfriendly and suspicious of me as the men, watching me in a most nerve-wracking manner to see how I would meet the challenge.”<sup>2</sup>

At Walter Reed, Lena Hitchcock served at the army’s flagship occupational therapy (OT) program for soldiers and veterans of the Great War. The Walter Reed program offered patients the opportunity to participate in activities such as knitting, woodwork, bookkeeping and typewriting. The primary purpose of OT programs for soldiers, from the perspective of army administrators, was to prime bodies and minds for economic self-reliance and productivity. Both soldiers and therapists attempted to extend the personal benefits of structurally and ideologically limited military OT programs like the one at Walter Reed: soldiers, by attempting to expand and

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<sup>1</sup> The quote is from a 1918 pamphlet intended for disabled, hospitalized soldiers: Federal Board for Vocational Education in Cooperation with the Surgeon General's Office and the War-Risk Insurance Bureau, "To the Disabled Soldier and Sailor in the Hospital (Rehabilitation Joint Series), Monograph No. 1" November, 1918. Montgomery Collection, Otis Historical Archives 245, Box 9, Folder: Legislation, etc. for O.T,

<sup>2</sup> Lena Hitchcock, "The Great Adventure" Undated manuscript, I-XI. Angier and Hitchcock Collection, Otis Historical Archives 97, Box 3, National Museum of Health and Medicine, Washington, D.C.

capitalize on the government's promise of educational opportunity; and therapists, by laying the groundwork for economic and professional advancement. Occupational therapy at military hospitals encapsulated a new type of military health care and demonstrated the extent to which soldiers were rehabilitated and prepared for civilian life under the auspices of the army.

The story of occupational therapy during the Great War helps illustrate the impact of pre-war policies geared at making domestic military hospitals the primary venue of treatment for injured and ill soldiers.<sup>3</sup> The tenets and machinations of the OT program of the Educational Section of the Army's Department of Physical Reconstruction make it clear that the government held, and unabashedly shared with soldiers gendered, market-focused goals for rehabilitation programs. An examination of the program's implementation at Walter Reed demonstrates that soldiers resisted therapeutic measures rooted in Progressive Era ideals of social control, which they deemed demeaning and feminizing. It also reveals that many of those who helped to structure army health care had respect for soldiers, but also distinct conceptions of what qualified them as heroic or "weak." Justifications for models of and access to care were based on such conceptions. Finally, a study of occupational therapy at Walter Reed highlights the stories of women like Lena Hitchcock. Even as she and her colleagues served as facilitators of a program based on gendered and racialized constructs that linked manliness with industrial usefulness, and female service to "tact," "charm," and an "attractive personality," they partook in an American tradition of pushing the boundaries of military infrastructure in order to enhance their own professional status and citizenship rights.

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<sup>3</sup> Lettie Gavin's informative account of reconstruction aides during the Great War focuses primarily on their experiences, perceptions, and treatment as women serving overseas. Lettie Gavin, *American Women in World War I: They Also Served* (Niwot, Colorado: University Press of Colorado, 1997), 101-21.



During World War I, the physical repair of United States troops was only one among many organizing principles of a burgeoning modern military health care system that meant different things to different groups. From the government's perspective, an efficient military medical system could bolster an image of military and scientific prowess and alleviate the possibility of a soldier becoming a life-long pensioner. For doctors and other health care personnel, military medical practice could provide a forum for professional and scientific development and advancement. White women (as nurses and therapists) and people of color (as nurses, doctors and enlistees) also attempted to use the army and its medical care institutions to advance their own claims on citizenship and professional rights. Other service members, given their varying wartime experiences and array of injuries and illnesses, had multi-dimensional understandings of the purpose of military medicine, and thus reacted differently to governmental, army, and professional efforts: some patients, for example, actively attempted to use hospitals as forums for education and rehabilitation; others resented and rejected such notions. Ill and wounded American soldiers were not a monolithic group; they were distinguished by race, class, and type of ailment. These personal attributes could heavily influence one's hospital experience.

*Army medicine before World War I and the roots of Walter Reed Army General Hospital*

The army's occupational therapy program was part of an organizational culture in transition. At the end of the nineteenth century, the Army Medical Department operated within a military that was focused – via wars with Indian tribes across the United States and engagements in Latin America and the Philippines – on the larger mission of American expansion and imperialism. After health debacles during the Spanish-American War, army doctors argued successfully that more resources needed to be devoted to preventive medicine and the staving off

of epidemic diseases. Their efforts were helped by the fact that typhoid, yellow fever, and malaria were increasingly seen as barriers to trade. In the first decade of the twentieth century, army doctors not only undertook disease research in countries boasting rich resources in order to make them safe for U.S. troops and business, they also fought for professional respect and control within the army. Their advocacy efforts reflected larger trends occurring in the civilian medical world, and a push towards a more modern army, one that was increasingly institutionalized and professionalized. Walter Reed Hospital, which began treating patients in 1909, was a symbol of the changing infrastructure of both the U.S. Army, and the role and perception of its medical services.

As European countries enhanced their military infrastructures in the 1870s, the United States embarked on a process of demilitarization following the bloodiest conflict in the young nation's history. In the wake of the Civil War in the 1860s, Army Medical Department officials advocated for increased staff and enhanced institutions. But their high hopes did not fit an "American army establishment that had been molded to fit a radically decentralized governmental order..."<sup>4</sup>

The situation began to change in the 1880s and early 1890s, when army higher-ups urged an expansion of American military power, both as a means of quelling widespread domestic labor conflicts, and as protection for the United States' burgeoning worldwide trade and economic interests.<sup>5</sup> Between 1890 and 1920, Samuel P. Huntington has argued, the U.S.

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<sup>4</sup> Stephen Skowronek, *Building a New American State: The Expansion of National Administrative Capacities, 1877-1920* (Cambridge: Cambridge University Press, 1982), 85-88. For general perspective on the development of the American military, see: Russell Frank Weigley, *Towards an American Army: Military Thought from Washington to Marshall* (New York: Columbia University Press, 1962). Russell Frank Weigley, *History of the United States Army* (Bloomington: Indiana University Press, 1984).

<sup>5</sup> Skowronek, *Building a New American State: The Expansion of National Administrative Capacities, 1877-1920* 85-88.

government and military officials had a “positive reaction to the end of isolation and a favorable response to the opportunity to play power politics.” During what Huntington refers to as the “Neo-Hamiltonian” period, policy-makers and army elites re-imagined American military ideals and structure.<sup>6</sup> Not all policy-makers, of course, were in the same camp – some were staunchly opposed to the expansion of a standing army they saw as a threat to republican values.<sup>7</sup> In spite of objections from the latter group, the share of the federal budget spent on the military grew from 20 to 40 percent between 1880 and 1905. Although the greatest share of those funds went to the exponentially growing navy (whose budget increased nearly eightfold in these years), the army fared relatively well for itself; its budget tripled.<sup>8</sup>

The mission and purview of the Army Medical Department expanded along with the larger military infrastructure, in part by virtue of the effects of the 1898 Spanish-American War. During that conflict, deaths due to disease far outnumbered deaths due to battle, and military hospital care was widely viewed as inadequate. In the aftermath of war, Congress and the general public were appalled that the U.S. had lost so many service members to diseases such as typhoid and yellow fever. And they were disturbed to learn of overcrowded army camps, where proper

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<sup>6</sup> Samuel P. Huntington, *The Soldier and the State: The Theory and Politics of Civil-Military Relations* (Cambridge, Mass Belknap Press of Harvard University Press, 1967), 270-89.

<sup>7</sup> Robert L. Beisner, *Twelve against Empire: The Anti-Imperialists 1898-1900* (New York: McGraw-Hill Book Company, 1968). Other helpful secondary sources: E. Berkeley Tompkins, *Anti-Imperialism in the United States: The Great Debate, 1890-1920* (Philadelphia: University of Pennsylvania Press, 1970). David Healy, *U.S. Expansionism: The Imperialist Urge in the 1890s* (Madison: University of Wisconsin Press, 1970); James L. Abrahamson, *America Arms for a New Century: The Making of a Great Military Power* (New York: The Free Press, 1981).

<sup>8</sup> Ben Baack and Edward Ray, "The Political Economy of the Origins of the Military-Industrial Complex in the United States," *The Journal of Economic History* Vol. 45, no. No. 2 (June 1985): 370.

medical care was lacking. The public outcry served as a major impetus for change in the area of military medical care.<sup>9</sup>

The Spanish-American War also furthered the army's pursuit of a larger public health mission. With U.S. troops occupying so-called tropical regions in Cuba, Puerto Rico, and the Philippines, Army Medical officers played an important role in the establishment of American hegemony.<sup>10</sup> Edward Erskine Hume, a member of the Army Medical Department from 1917 through 1952, argued that international medical research and regimented public health campaigns could be represented as both humanitarian in nature, and as an encapsulation of American scientific prowess. Hume argued that the "word 'health' is a talisman which can successfully unlock many a domestic as well as foreign door." Even "when civil authorities do not cooperate in a satisfactory manner with the military," he said, "it is hard to imagine a situation in which there is friction between the military and civil officers of health." Hume suggested that "many a wise military commander has, by means of the friendly relations between

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<sup>9</sup> One of the more comprehensive sources on the challenges faced by the army during the Spanish-American War is Graham A. Cosmas, *An Army for Empire; the United States Army in the Spanish-American War* (Columbia: University of Missouri Press, 1971). For more on medical care during the conflict, see Jessica L. Adler, "A Very Necessary Institution: The Founding of Walter Reed Army General Hospital," Walter Reed Army Medical Center Centennial Symposium, (Washington, D.C., April 2009).

<sup>10</sup> A wide literature exists on the notion of public health campaigns being used – by both the government and private organizations such as the Rockefeller Foundation – for imperialistic ends. See, for example: Warwick Anderson, *Colonial Pathologies: American Tropical Medicine, Race, and Hygiene in the Philippines* (Durham: Duke University Press, 2006). Steven Palmer, "Central American Encounters with Rockefeller Public Health, 1914-1921," in *Close Encounters of Empire: Writing the Cultural History of U.S.-Latin American Relations*, ed. Catherine C. Legrand (Chapel Hill, North Carolina: Duke University Press, 1998). *Missionaries of Science: The Rockefeller Foundation and Latin America* ed. Marcos Cueto (Bloomington: Indiana University Press, 1994). Anne-Emanuelle Birn, "Public Health or Public Menace," *Voluntas: International Journal of Voluntary and Nonprofit Organizations* Vol. 7, no. No. 1 (March 1996). S. Franco-Agudelo, "The Rockefeller Foundation's Antimalarial Program in Latin America: Donating or Dominating?," *International Journal of Health Services* Vol. 13, no. No. 1 (1983). Nancy Leys Stepan, "The Interplay between Socio-Economic Factors and Medical Research: Yellow Fever Research, Cuba and the United States," *Social Studies of Science* 8, no. 4 (November 1978).

the medical officers of such commands and their civilian colleagues, brought about a complete understanding and team work with civil authorities.”<sup>11</sup>

While generally prioritizing the health of U.S. troops as opposed to local citizens, army doctors undertook fruitful campaigns around the turn of the century aimed at the eradication of some of the major epidemic threats of the time: yellow fever, hookworm, and typhoid, among others.<sup>12</sup> Their efforts were fostered by the United States’ burgeoning economic interest in its neighbors to the south. The latter helped bring about the 1890 founding of the Pan American Union, intended to serve as a forum for the discussion of trade regulations in the region, and the related 1902 establishment of the Pan American Health Organization, which aimed to devise standardized measures to stave off the spread of disease.<sup>13</sup>

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<sup>11</sup> Edgar Erskine Hume, "The United States Army Medical Department and Its Relation to Public Health," *Science* 74, no. 1924 (1931).

<sup>12</sup> Bobby A. Wintermute, *Public Health and the U.S. Military: A History of the Army Medical Department, 1818-1917*, *Advances in American History* (New York, New York: Routledge, 2011), See especially Chapter Four.

<sup>13</sup> On the Pan American Health Organization, see Marcos Cueto, *The Value of Health: A History of the Pan American Health Organization* (Washington, DC: Pan American Health Organization 2007). Myron E. Wegman, "A Salute to the Pan American Health Organization," *American Journal of Public Health* Vol. 67, no. No. 12 (December 1977). Aristides A. Moll, *Half a Century of Medical and Public Health Progress, 1890-1940: Fiftieth Anniversary of the Pan American Union, 1890-1940* (Washington, D.C.: Pan American Health Organization, 1940). On the Pan American Union, see Jerome Slater, *The O.A.S. And United States Foreign Policy* (Columbus, Ohio: Ohio State University Press, 1967). Lloyd J. Mechem, *The United States and Inter-American Security, 1889-1960* (Austin, Texas: University of Texas Press, 1961).



*"Ward in Spanish Military Hospital – Ponce (Typhoid cases)"*<sup>14</sup>

After the Spanish-American War, between 1902 and 1916, the army's mission and physical presence expanded as the reforms of Elihu Root, who was Secretary of War from 1899 through 1904, "laid the foundations for a modern army."<sup>15</sup> In those years, as the army attempted to create a streamlined organizational structure and a sense of professionalism, it spent just two percent of its funding on the purchase of arms.<sup>16</sup> Root's reforms ensured that the "other" 98 percent would be spent on institutionalizing the military beyond tanks and guns. They not only provided more centralized control at the highest level of army administration and laid the

<sup>14</sup> "Ward in Spanish Military Hospital, Ponce, (Typhoid Cases)", Undated. Otis Historical Archives 516 Spanish-American Photo Collection, National Museum of Health and Medicine, Washington, D.C.

<sup>15</sup> Paul Koistinen, *Mobilizing for Modern War: The Political Economy of American Warfare, 1865-1919*, Modern War Studies (Lawrence, Kan.: University Press of Kansas, 1997), 88. Koistinen also points out that between 1902 and 1916, the "average peacetime strength of the army was over three times greater than in the period 1872 to 1897, and average annual budgets in adjusted dollars were almost four times as large." Graham A. Cosmas, who argues that the defeat of proposed military reforms in 1898-1899 laid the groundwork for later army reorganization, highlights the notion that the fight for army expansion was rooted in drives toward professionalism following the Spanish-American War. Graham A. Cosmas, "Military Reform after the Spanish-American War: The Army Reorganization Fight of 1898-1899 " *Military Affairs* 35, no. 1 (February 1971).

<sup>16</sup> The statistic regarding funding spent on arms is from Ray, "The Political Economy of the Origins of the Military-Industrial Complex in the United States," 370.

groundwork for the modern-day National Guard, but also led to the 1903 creation of the Army War College and the enhancement of several military branches.<sup>17</sup>

In the years surrounding Root's tenure as Secretary of War, military medicine followed trends evident in the civilian medical world, which was becoming increasingly professionalized, and centered on ever-stricter standards for education. Beginning in 1847, with the formation of the American Medical Association, physicians banded together to forward standard models of certification.<sup>18</sup> Abraham Flexner's 1910 report on medical education, which argued for the necessity of universal degree requirements for physicians, articulated some of the primary concerns of a newly powerful interest group.<sup>19</sup> Scholars have pointed out three major outcomes of Flexner's report: it led to the shutting down of "mediocre" medical schools with predominantly African American and female student populations, thus making mainstream medical education and practice accessible mainly to a select few; it successfully argued that analytic reasoning should serve as the basis for medical education; and finally, it established that clinical practice would constitute a critical phase of medical training. The latter had the larger effect of accelerating a trend that was already underway – the affiliation of medical schools with hospitals.<sup>20</sup> The health care infrastructure of the U.S. Army was embedded in this larger medical

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<sup>17</sup> James L. Yarrison, "The U.S. Army in the Root Reform Era, 1899-1917," <http://www.history.army.mil/documents/1901/Root-Ovr.htm>.

<sup>18</sup> Frank Billings, "An Historical Sketch of the American Medical Association," *Medical Library and Historical Journal* 2, no. 2 (1904).

<sup>19</sup> Abraham Flexner, *Medical Education in the United States and Canada: A Report to the Carnegie Foundation for the Advancement of Teaching* (Washington, D.C.: Carnegie Foundation for the Advancement of Teaching, 1910).

<sup>20</sup> For an analytical overview of the report: Molly Cooke; David M. Irby; Kenneth M. Ludmerer; William Sullivan, "American Medical Education 100 Years after the Flexner Report," *New England Journal of Medicine* Volume 355(September 28, 2006). Thanks to the efforts of Flexner and the increasingly powerful A.M.A., Richard Brown argues, doctors went from being perceived as a disorganized group of middle class technicians, to being seen as powerful professionals with access to specialized knowledge unavailable to the masses. Richard E. Brown, *Rockefeller Medicine Men: Medicine and Capitalism in America* (Berkeley: University of California, 1979). Paul Starr, like Brown, represents scientific advances and discoveries less as arbitrary determinants of doctors' authority,

culture. Army doctors fought vigorously at the turn of the twentieth century for respect and professional legitimacy. Their campaigns for better pay, increased staff, and higher professional and institutional standards helped bring about the 1886 creation of a Hospital Corps, the 1893 establishment of the Army Medical School, the 1908 recognition of the Medical Corps, and the 1911 founding of the Dental Corps.<sup>21</sup>

Around this time, army doctors began advocating for a new army general hospital near the nation's capital, a facility they argued could serve as a beacon in a military hospital system dominated by small, far-flung, often ramshackle post hospitals.<sup>22</sup> One of the main differences between a general hospital and a post hospital was that the former could serve as a haven for treatment for a variety of types of complex cases, and was under the command of the Army Surgeon General, whereas the latter was under the control of the post commander. By 1900 some general hospitals founded in the years surrounding the Spanish-American War had been closed, but four continued to serve patients. There were two facilities that served as magnet institutions of sorts, treating all types of patients: the General Hospital at San Francisco (re-named Letterman General Hospital in 1911) and the Army General Hospital at Washington Barracks in Washington, D.C., the predecessor to Walter Reed, which advocates argued was in dire need of modernization.<sup>23</sup> Additionally, two specialty-care general hospitals treated soldiers during and

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than as mechanisms by which physicians gained legitimacy. For example, although the antitoxin discovered for the treatment of diphtheria in the 1890s benefited a relatively small number of patients, Starr notes, it had the exponentially larger effect of encouraging parents to consult physicians whenever a child developed a sore throat. Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982).

<sup>21</sup> For more details on the "organizational revolution" in the Army Medical Department at the turn of the century, see: Wintemute, *Public Health and the U.S. Military: A History of the Army Medical Department, 1818-1917*. Also, Mary C. Gillett, *The Army Medical Department, 1865-1917*, Army Historical Series (Washington, D.C.: Center of Military History, United States Army, 1995), 313-41.

<sup>22</sup> Gillett, *The Army Medical Department, 1865-1917*, 51-52.

<sup>23</sup> *Ibid.*, 336-39.



after the war. The oldest of all the permanent general hospitals, founded in 1887 at Hot Springs, Arkansas, served patients with conditions such as syphilis, rheumatism, neuralgia and skin diseases, which might benefit from treatment with hot mineral waters – the Arkansas hospital’s main attraction.<sup>24</sup> The other specialized-care army general hospital, which focused largely on the treatment of tuberculosis, was opened in 1899 in Fort Bayard, New Mexico.

Army doctors perceived a new Washington, D.C.-based general hospital as an opportune locus of control. They argued that the problems surrounding the administration of medical care during the Spanish-American War stemmed from the fact that army physicians lacked authority.<sup>25</sup> In his account of field medicine in the Cuban campaign of the Spanish-American War, Graham A. Cosmas bolsters this idea: “Surgeons in camp and field had no power to enforce their recommendations for sanitation, and commanders often brushed aside their warnings and suggestions and even belittled the medics as fussy old women who tried to coddle the soldiers.”<sup>26</sup> If a state-of-the-art general hospital existed near Washington, D.C., many Army Medical Department officials felt, they would have control over a permanent, reliable institution, and be more able to provide high-quality care.

Advocates of a new general hospital also noted other potential benefits of such an institution. It could be an educational asset, they said, used in the instruction of personnel of the Hospital Corps, who served as ward masters, nurses, cooks, and orderlies, as well as in the

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<sup>24</sup> Ibid., 50-52.

<sup>25</sup> For a detailed account of the founding of Walter Reed, including more on scandals during the Spanish-American War surrounding hospital care, see Adler, "A Very Necessary Institution: The Founding of Walter Reed Army General Hospital,"

<sup>26</sup> Cosmas, *An Army for Empire; the United States Army in the Spanish-American War*, 246.

curriculum for students of the Washington, D.C.-based Army Medical School.<sup>27</sup> Two other central functions of the proposed general hospital would be to treat so-called “special cases,” and to review cases of officers seeking discharge due to disability. Special cases were defined according to the interests of both the soldier and the government. “Cases of illness and injury are constantly arising in the military service which require special skill and special appliances for their treatment in order to save the men to the service, to reduce the pension list, and to give men disabled in the service of their country the benefit of the most advanced medical and surgical knowledge,” said the 1902 Surgeon General’s report. As was the case in the civilian medical world, the report continued, it was impossible to outfit every hospital with the proper equipment and medical personnel to treat every patient. In civilian life, patients from the country and small towns and cities were regularly sent to medical centers with “specially trained medical men in attendance.”<sup>28</sup> A similar model should exist in the military; complicated medical cases of officers and enlisted men should be overseen within the army infrastructure, not outsourced to large civilian hospitals (as had been the case during the Spanish-American War). “The military service,” according to the Surgeon General, should “hold control of its own cases.”<sup>29</sup>

The Surgeon General’s justifications for sending soldiers seeking discharge due to disability to a new general hospital was pragmatic: “(Officers’) real physical condition when claim of permanent disability is made is often a matter of conjecture. It is important that if disability is not permanent that this fact be ascertained and the officer saved to the government.”

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<sup>27</sup> A detailed historical study of the Army Medical School is lacking, but for a general overview, see Gillett, *The Army Medical Department, 1865-1917*, 97-99. On the Hospital Corps, see ———, *The Army Medical Department, 1865-1917*, 20.

<sup>28</sup> The report is cited in: United States Congressional Record, House, January 25, 1904, Fifty-Eighth Congress, Second Session, (Washington, DC: Government Printing Office, 1904), 1150.

<sup>29</sup> Annual Report of the Surgeon General to the Secretary of War, 1902, (Washington, DC: Government Printing Office, 1902), 138.

The Surgeon General's report acknowledged that transport to a Washington, D.C. general hospital from posts scattered throughout the country for assessment would mean an "increased expenditure for mileage." But, soldiers and officers would never come from further west than the Rocky Mountains; personnel who sought medical attention from that region would be sent to the general hospital at San Francisco. In any case, the Surgeon General noted, the cost of transport was "insignificant when compared with the saving of a trained officer or man to the service who would otherwise either die or have to be supported for the rest of his life on the retired list or as a pensioner."<sup>30</sup>



*"Company of Instruction Training at Washington Barracks"*<sup>31</sup>

Funding for what became Walter Reed Army General Hospital was included in a 1905 civil appropriations bill under a section entitled "Miscellaneous Objects, War Department."

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<sup>30</sup> Cited in: United States Congressional Record, House, January 25, 1904, 1150.

<sup>31</sup> Accessed via <http://history.amedd.army.mil/booksdocs/spanam/gillet3/default.html>

\$100,000 was allotted for the purchase of the site, and \$200,000 more for hospital construction.<sup>32</sup>

When the Georgian-style main building of Walter Reed was erected in 1908 containing 80 beds, it was praised by *The Washington Post* as being “modern in every detail” and “of stately Colonial style.”<sup>33</sup>

In its early years, Walter Reed operated as the post hospital for Washington Barracks and a general hospital for the United States east of the Mississippi. Between 1911 and 1916, the number of patients admitted at the hospital increased from 565 per year to 1,350. Venereal disease was a common ailment among patients, as was tonsillitis and appendicitis, but reasons for admission and surgeries performed were highly varied. Throughout the period, the Washington, D.C.-based Army Medical School maintained an active relationship with Walter Reed, performing thousands of Wasserman tests each year in order to ascertain whether patients had syphilis, in addition to blood cultures and “laboratory examinations of pathologic specimens.” Walter Reed’s Commanders in the 1910s also worked hard to ensure that the hospital would grow – aesthetically – “into a general hospital that shall be a credit to the army.” They reported that enlisted men helped plant hundreds of trees, bushes, and flowers, and undertook infrastructural improvements such as road repair and installing new outdoor light fixtures. In 1916, the hospital was still somewhat of a small operation: it had a 180-bed capacity and an average of nine medical officers on duty, along with 26 nurses.<sup>34</sup>

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<sup>32</sup> An Act Making Appropriations for Sundry Civil Expenses of the Government for the Fiscal Year Ending June Thirtieth, Nineteen Hundred and Six, and for Other Purposes, Public Law 216, H.R. 18969, 33 Stat. 1156, Fifty-Eighth Congress, Third Session, (Washington, D.C.: Government Printing Office, March 3, 1905), 1197.

<sup>33</sup> "Hospital up to Date," *The Washington Post* (1877-1954) 1908.

<sup>34</sup> "Walter Reed Army General Hospital Annual Report For...", 1911-1920. Records of the Office of the Surgeon General, RG 112, Box 1, Entry 401, National Archives and Records Administration, Washington, D.C. The quote is from the 1913 Annual Report.



*Exterior view of Walter Reed Army General Hospital, 1917. As the army planned a comprehensive rehabilitation program in the World War I era, facilities and services at the institution grew exponentially.<sup>35</sup>*

With the onset of World War I, both Walter Reed and the Army Medical Department underwent major transitions. The hospital went from being a young facility providing treatment for a relatively small (albeit growing) number of service members to serving as a destination institution for some of the most complex medical cases in a large and hastily assembled army. On a broader level, the Great War marked a major turning point for the Army Medical Department. It saw, as historian Bobby Wintermute argues, a new turn toward the heroic possibilities of combat medicine.<sup>36</sup> As an extension of this new turn – and as a result of the very real conditions of war – the army devoted increased resources to domestic institutional medical care for soldiers.<sup>37</sup>

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<sup>35</sup> "Aerial View, Walter Reed Army General Hospital", 1917. Otis Historical Archive 355, Box 5, Folder: Photos – Aerial Views, National Museum of Health and Medicine, Washington, D.C.

<sup>36</sup> Wintermute, *Public Health and the U.S. Military: A History of the Army Medical Department, 1818-1917*.

<sup>37</sup> Developing hostilities along the Mexico-U.S. border in 1916 provided Army Medical Department personnel with opportunities for field-based (as opposed to Army Medical School-based) training. Still, in spite of that – and in spite of increases in appropriations to the army and administrative improvements in its medical services in first decade of the twentieth century – army officials (and Medical Department officers) reported feeling critically

The services administered and numbers treated at Walter Reed Army General Hospital greatly expanded during the war. In June 1917, construction of temporary buildings began, including additional nurses' quarters, barracks, a mess hall, a store house, and a guard house, among other structures. That year, approximately 4,300 patients were admitted to the hospital and an average of 23 medical officers were on duty, along with 44 nurses.<sup>38</sup> In 1918, admissions swelled to a wartime peak of 14,435 patients. By that point, there were an average of 86 officers and 148 army nurses on duty, in addition to about 34 reconstruction aides and numerous other civilian personnel.<sup>39</sup> In 1918, Walter Reed had many characteristics of a major medical center. It offered specialized services in orthopedics, neurosurgery, amputations, dermatology, urology, and eye, ear, nose, and throat, among others. It was also home to the new Army School of Nursing, a laboratory with bacteriological, chemical, and pathological sections, and physiotherapy, occupational therapy, and vocational education departments.<sup>40</sup>

### The wounded

Sick and wounded World War I-era military personnel – the people most likely to fill military, and later, veterans' hospital beds – could be classified in at least three broad categories.

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unprepared for the grand scale of World War I. For a general picture of the Army Medical Department's mobilization for war, see Gillett, *The Army Medical Department, 1865-1917*, especially the "Prologue".

<sup>38</sup> "Annual Report of Walter Reed Army General Hospital for 1917", May 2, 1918. Records of the Office of the Surgeon General, RG 112, Box 1, Entry 401, National Archives and Records Administration, Washington, D.C.

<sup>39</sup> "Walter Reed Army General Hospital Annual Report for 1918", January 30, 1919. Records of the Office of the Surgeon General, RG 112, Box 1, Entry 401, Folder: Annual Report 1918, National Archives and Records Administration, Washington, D.C. According to a post-war report, 13,752 patients were admitted to Walter Reed in 1918, a slightly lower estimate. Frank W. Weed, *Medical Department of the United States Army in the World War; Volume 5: Military Hospitals in the United States*, ed. M.W. Ireland (Washington, D.C.: Government Printing Office, 1923), 305.

<sup>40</sup> Weed, *Medical Department of the United States Army in the World War; Volume 5: Military Hospitals in the United States*, 287-8.

Hundreds of thousands of troops (one estimate puts the number at slightly more than 200,000) were inducted into the military by local draft boards, but upon arrival at their respective army camps, deemed physically or mentally unacceptable for service.<sup>41</sup> One official explained the numbers by noting ‘the hasty and superficial examinations given by inexperienced and indifferent medical examiners for enlistment, immediately following the declaration of war...’<sup>42</sup> It did not help that standards for acceptance into the army changed over time, and local draft boards were “overworked and undermanned in the face of a large flow of recruits.”<sup>43</sup> A sampling of approximately 52,600 of these accepted but later rejected men showed that almost 9,000 were denied entry into the army due to “diseases of bones and organs of locomotion.” Eye, digestive, and circulatory system diseases each accounted for between 7,000 and 8,000 rejections. Another 4,700 accepted by local draft boards were found to have tuberculosis upon arrival at army camps; 3,500 were diagnosed with “mental diseases.” Slightly more than 2,000 were rejected on the grounds that they had venereal diseases.<sup>44</sup>

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<sup>41</sup> The 200,300 estimate seems relatively reliable. According to a government report, between June 1917 and February 1918, 28,300 men were accepted by local draft boards but rejected at camps. Another 172,000 were accepted then later rejected between February 1918 and November 1918. Hearings before the Committee on Public Buildings and Grounds, House of Representatives, on Additional Hospital Facilities for Discharged Soldiers, Sailors, Marines, and Army and Navy Nurses, H. Doc. No. 481, Sixty-Sixth Congress, Second Session, (Washington, D.C.: Government Printing Office, April 26, 1920), 32. A later report puts the number considerably higher, at more than 740,000. R.E. Adkins, *Medical Care of Veterans*, Ninetieth Congress, First Session, (Washington, D.C. : United States Government Printing Office, April 1967).

<sup>42</sup> Annual Report of the Surgeon General of the Public Health Service of the United States for the Fiscal Year 1918, (Washington, D.C.: Government Printing Office, 1918), 19.

<sup>43</sup> The quote is from Patrick W. Kelley, *Military Preventive Medicine: Mobilization and Deployment, Volume 1* (Washington, D.C.: The Office of the Surgeon General, Borden Institute, 2003), 149. In addition to those accepted and later turned away at camps, one in three men eligible to serve was rejected for lack of physical fitness by local draft boards between September 1917 and November 1918, according to Kelley. After November 1918, he notes, standards for entry were loosened and the rejection rate dropped to one in four. On local draft boards, army standards for entry, and rejection rates, also see Jennifer D. Keene, *Doughboys, the Great War, and the Remaking of America* (Baltimore: The Johns Hopkins University Press, 2001), 26.

<sup>44</sup> Additional Hospital Facilities for Discharged Soldiers, Sailors, Marines, and Army and Navy Nurses, House Document No. 481, Sixty-Sixth Congress, Second Session, (Washington, D.C.: Government Printing Office, December 8, 1919), 34-35.

There was uncertainty and disagreement about whether this group was entitled to the compensation and medical care guaranteed by the War Risk Insurance Act (WRIA). The Army Judge Advocate General ruled that, “a man who has been accepted by a draft board and dispatched to a camp had been drafted into active service.” But the Bureau of War Risk Insurance, the government agency responsible for allocating the compensation and medical care under the WRIA, held that “the man did not actually enter active service until he was accepted by the medical officers of the army.”<sup>45</sup> Public Law 104, passed December 24, 1919, settled the matter. Much to the chagrin of some members of Congress and medical professionals, it stipulated that these many thousands of troops were eligible for compensation and medical care, in spite of never having rendered service in any official capacity. They were, the law held, officially hired by the U.S. government once they were accepted by their local draft boards, and therefore deserving of subsequent disability benefits.<sup>46</sup>

The second group eligible for care as soldiers and later, as discharged veterans, included those who never saw service abroad, but who fell ill while stationed at camps or bases in the U.S. In October 1918, when the army was at its peak strength, there were approximately 1.9 million troops serving in Europe, 1.6 million in the United States, and 300,000 in other countries.<sup>47</sup> Approximately 75 percent of discharges for diseases such as tuberculosis, venereal diseases, and “mental deficiency” were among soldiers who never left the U.S.<sup>48</sup> After the war, advocates of

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<sup>45</sup> Hearings before the Committee on Public Buildings and Grounds, House of Representatives, on Additional Hospital Facilities for Discharged Soldiers, Sailors, Marines, and Army and Navy Nurses, H. Doc. No. 481, 79-80.

<sup>46</sup> An Act to Amend and Modify the War Risk Insurance Act, Public Law 104, H.R. 8778, 41 Stat. 371, Sixty-Sixth Congress, Second Session, (Washington, D.C.: Government Printing Office, December 24, 1919).

<sup>47</sup> Albert G. Love, *The Medical Department of the United States Army in the World War, Volume Xv, Part Two: Medical and Casualty Statistics* (Washington, D.C.: Government Printing Office, 1925), 15-18.

<sup>48</sup> *Ibid.*, For a breakdown of causes of admissions and discharges, and locations of discharged soldiers, see p. 1183. For a detailed description of “discharges by condition,” see p. 166-189.



military medical care boasted that those statistics demonstrated “evidence of the efficiency of preventive medicine” at the front. In retrospect, one analyst argued that a large number of soldiers eventually discharged due to disease were ill upon enlistment, seeing as a “great majority” never saw overseas service.<sup>49</sup> That assertion was difficult to prove, given that military camps were breeding grounds for influenza, tuberculosis, and other diseases. As we will see, army rehabilitation officials felt as though this group of patients was decidedly less deserving of treatment than those who had returned from the front. As the war effort waned and funds dried up, many others would argue that the lack of glowing service records among some of those who sought medical care justified a lessened government responsibility to veterans.

The third group of military personnel treated for injuries and illnesses were those who served abroad. Approximately 224,000 soldiers were wounded in action during World War I, in addition to almost 10,000 Marines. More than 65 percent of injuries resulted from gunshot wounds, and about 32 percent from poisonous gases. Some of the battle-wounded were treated in military hospitals abroad and either discharged, or sent back to the front lines. But between April 1918 and December 1919, approximately 52,000 of the more than 147,000 service members transferred to the U.S. from overseas hospitals went on to receive further care in domestic military hospitals.<sup>50</sup>

The wounded from overseas were generally gathered from their locations near the front in base hospitals in France then brought by hospital train to embarkation hospitals at one of two French ports. The soldiers were then transported – by a naval hospital ship or army vessel – to a U.S. port at either Hoboken, New Jersey or Newport News, Virginia. There, they were housed at

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<sup>49</sup> ———, “A Brief Summary of the Vital Statistics of the U.S. Army During the World War,” *The Military Surgeon* Vol. LI, Number 2(August 1922): 146-48.

<sup>50</sup> *Ibid.*: 165.

debarkation hospitals while medical officers determined which domestic base or general hospital was best suited to care for them, and sought approval for their placement from the Surgeon General's Hospital Division. Although an effort was made to locate soldiers close to their own homes, their medical conditions were the most important factors when it came to determining where they would be treated.<sup>51</sup>

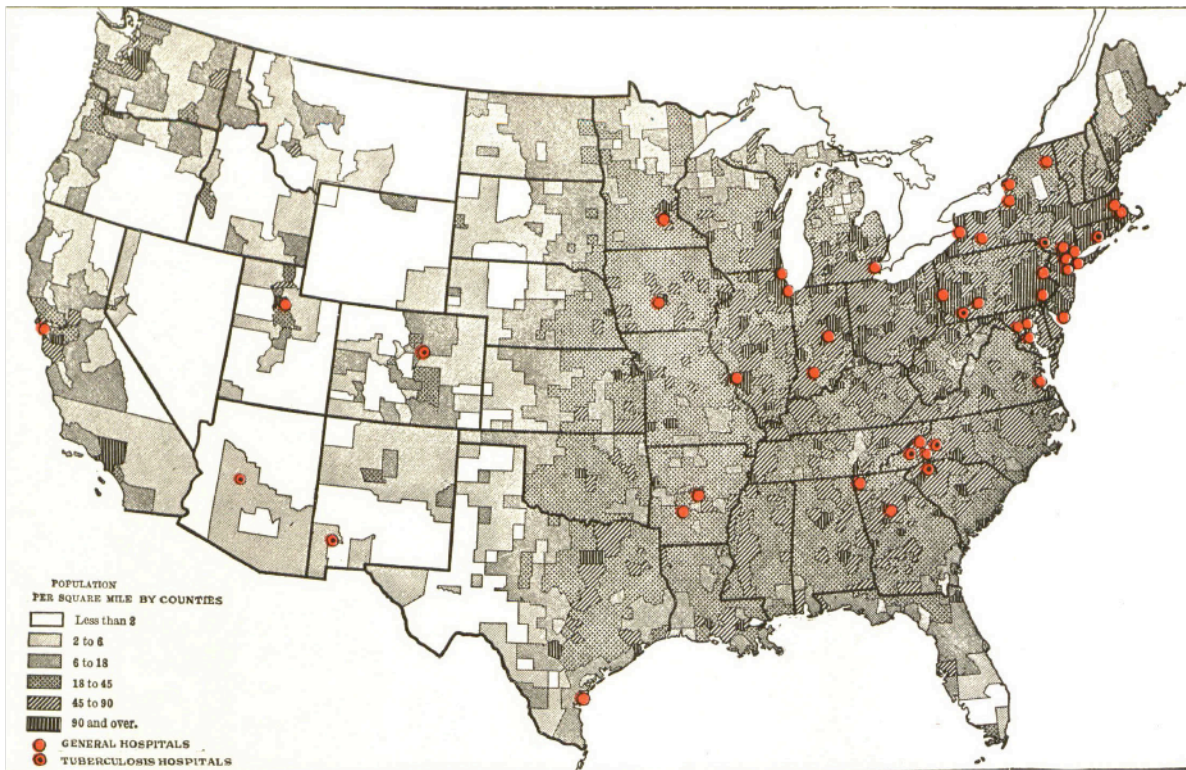
"Equipped for the care and treatment of all varieties of injury and disease," general hospitals were different from camp, base, or embarkation hospitals, in that they focused on the treatment of soldiers with complex medical conditions, especially those who had served abroad. The number of general hospitals varied throughout the war effort, but more than 50 existed at one point. Some specialized in treating patients with certain conditions, such as tuberculosis or shell-shock; one – General Hospital No. 7 at Baltimore, Maryland provided care for patients who had been blinded. But virtually all were focused on the general mission of meeting "any surgical or medical requirement."<sup>52</sup> In May 1919, there were almost 40,000 beds available in general hospitals across the country.<sup>53</sup> Among these many institutions, Walter Reed Army General Hospital in Washington, D.C. was a flagship.

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<sup>51</sup> For a description on the transport of ill and injured troops from overseas to the U.S., and the types of hospitals available, see Mary C. Gillett, *The Army Medical Department, 1917-1941* (Washington, D.C.: Center of Military History, United States Army, 2009), 417-55. For an exhaustive account of military hospitals during the war, see Weed, *Medical Department of the United States Army in the World War; Volume 5: Military Hospitals in the United States*.

<sup>52</sup> Weed, *Medical Department of the United States Army in the World War; Volume 5: Military Hospitals in the United States*, 35.

<sup>53</sup> *Ibid.*, 54.



*“General hospitals superimposed upon Bureau of Census population map of 1910”<sup>54</sup>*

### *The origins and ideals of occupational therapy*

The roots of the army’s occupational therapy program were planted in the late nineteenth century, when women reformers involved in the settlement house and mental hygiene movements found eager partners in male medical practitioners striving to establish the importance of the mind-body connection in health. At the Hull House in Chicago, workers and the upper classes alike could partake in arts and crafts such as weaving and design – activities that later qualified as occupational therapy. The goals of such endeavors differed according to a subject’s social standing; Progressive reformers believed the activities could quell the revolutionary impulses of dissatisfied workers, or “return to productive life... an incipient

<sup>54</sup> Ibid., 35.

leadership class.”<sup>55</sup> Society ladies saw in arts and crafts the opportunity “as non-working-class people to capture what they perceived to be a productive and meaningful life experience.” Working-class men and women, on the other hand, could use arts and crafts to “feel more connected to and less hostile toward factory processes of labor.” By allowing the impoverished immigrant worker to partake in the production process from start to finish, the theory went, he or she could appreciate the meaning behind a monotonous assembly line job.<sup>56</sup> Doctors also found that allowing ill hospital patients to partake in activities such as sewing and woodworking assisted with their “normalization.”<sup>57</sup> By the outbreak of World War I, clinics using crafts for the treatment of patients with chronic physical illness existed in San Francisco, upstate New York, and New York City. By 1917, OT had gained enough legitimacy to be included in the United States government’s plans for the treatment of wounded soldiers of the Great War.<sup>58</sup>

In February 1918, the Surgeon General’s Office undertook its first trial of occupational therapy at Walter Reed Army General Hospital. The program began modestly, in the home of the institution’s handyman, who instructed patients in “the simplest kind of carpentry.” In April 1918, the Division of Physical Reconstruction of the Surgeon General’s Office allotted \$3,000 for therapy tools and staff. By the end of 1918, a comprehensive educational program was in place offering arts and crafts classes such as drawing, wood carving, jewelry making, engraving, and rug weaving, in addition to “commercial work,” which consisted of more vocationally-

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<sup>55</sup> T.J. Jackson Lears, *No Place of Grace: Antimodernism and the Transformation of American Culture 1880-1920* (New York: Pantheon Books, 1981), 71, 78.

<sup>56</sup> Virginia Anne Metaxas Quiroga, *Occupational Therapy: The First 30 Years, 1900 to 1930* (Bethesda, MD: The American Occupational Therapy Association, 1995), 36-41.

<sup>57</sup> *Occupational Therapy: Principles and Practice*, ed. William Rush Dunton and Sidney Licht (Springfield, Illinois: Charles C. Thomas 1950), 1.

<sup>58</sup> Quiroga, *Occupational Therapy: The First 30 Years, 1900 to 1930*, 36-41, 115, 52-5.

centered activities, such as bookkeeping, typewriting, automobile repair and “truck farming out of doors.”<sup>59</sup> The Walter Reed program served as a model for other army medical institutions. By mid-1919, approximately 350 occupational therapists had served in 52 U.S. army reconstruction hospitals.<sup>60</sup>

By encouraging participation in occupational therapy, the army aimed for medical progress and social control. According to a January 1919 report from the newly formed Walter Reed Occupational Therapy Department, the goals of arts and crafts and commercial work at the hospital were manifold, but above all, pragmatic and industrially-oriented. “The specific purpose,” the report said, “is to help each patient find himself and function again as a complete man, physically, socially, educationally and economically.” In a physical sense, OT could help “restore his body so far as possible to its normal condition.” In terms of education, it could “[furnish] him with such a training that he may make the most of his mental and physical resources and increase his personal efficiency.” The social and economic goals of OT included, according to the report, “enabling [the soldier] to feel that despite his physical handicap he may still be a self-reliant and self-respecting member of the community,” and “providing him a means of earning a comfortable livelihood so that with his return to civil life he may be an economic asset instead of a liability.”<sup>61</sup>

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<sup>59</sup> Major B.T. Baldwin, "Report of the Department of Occupational Therapy, Walter Reed General Hospital, Takoma Park, D.C." January 30, 1919. Otis Historical Archive, 245, Montgomery Collection, Box 14, Folder: Reports, National Museum of Health and Medicine, Washington, D.C. Weed, *Medical Department of the United States Army in the World War; Volume 5: Military Hospitals in the United States*, 311-2.

<sup>60</sup> Quiroga, *Occupational Therapy: The First 30 Years, 1900 to 1930*, 173.

<sup>61</sup> Baldwin, "Report of the Department of Occupational Therapy, Walter Reed General Hospital, Takoma Park, D.C.", 6-7.

Both occupational and vocational education officials focused on the benefits of work for recovering soldiers.<sup>62</sup> “The best way to bring back courage to a wounded soldier and the best way to restore the use of a stiff elbow is to employ the man and his elbow in useful work, naturally taking care not to overdo the process,” wrote Herbert J. Hall, who would serve as president of the American Occupational Therapy Association from 1920-1923. “Idleness,” he added, “means degeneration of body and spirit.”<sup>63</sup> A pamphlet issued by the Federal Board for Vocational Education (FBVE) noted the dual emphasis – on body and mind – of work therapy. Aside from allowing exercise of joints, it would create a “wholesome interest in something outside the patient’s morbid interest in himself and his symptoms” and prepare a soldier’s “mental attitude” for “normal demands” of the world outside the hospital.<sup>64</sup>

Government agency publications proudly trumpeted the goals of work-focused rehabilitation directly to soldiers and veterans. A pamphlet from the FBVE, “To the Disabled Soldier and Sailor in the Hospital,” was frank about the motivation behind encouraging soldiers to participate in rehabilitation efforts before leaving military hospitals. Following a detailed account of an array of government services and benefits available for disabled soldiers, the publication used a question and answer format to illustrate its point:

Why is my country so anxious to help me ‘go over the top’ into civil life?

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<sup>62</sup> The formative work on the relation of World War I to the civilian working world, and the shaping of the working class, remains David Montgomery, *The Fall of the House of Labor: The Workplace, the State, and American Labor Activism, 1865-1925* (Cambridge: Cambridge University Press, 1987), especially Chapter 7-9.

<sup>63</sup> Herbert J. Hall, "Bedside and Wheel-Chair Occupations " *Publications of the Red Cross Institute for Crippled and Disabled Men* II, no. 5 (February 25, 1919): 7-8.

<sup>64</sup> The Federal Board for Vocational Education, "Training of Teachers for Occupational Therapy for the Rehabilitation of Disabled Soldiers and Sailors, Bulletin No. 6" February 1918. Montgomery Collection, Otis Historical Archives, Box 14, Folder: "Training of Teachers...", National Museum of Health and Medicine, Washington, D.C.

It wants to conserve you as a part of its precious man power. Every man restored to profitable occupation is an asset, and hence a relief to the nation. Every man who fails to contribute to production is a liability, and hence a burden to the Nation. Don't add to her burden by being just one more man diverted from industry who does not get back again. Take your place and carry on.<sup>65</sup>

As the pamphlet indicated, the soldier's proper "place" was in a steady job in industry, one that allowed him to reclaim the manhood threatened by disability. At Walter Reed, participation in occupational therapy and commercial education classes was a means of proactively attempting to better one's situation.

*Carry On*, a magazine published by the Red Cross, edited by the Office of the Surgeon General, and available to patients in hospitals like Walter Reed, pointed out the utility of occupational therapy by arguing that "the making of some useful object has roused the interest of many a despondent man and brought him to a realization that he can again become fit and productive – an inspiring outlook for the man who once thought he was down and out."<sup>66</sup> The cover of the April 1919 issue of *Carry On* furthered this perspective when it published the "Creed of the Disabled: once more to be useful – to see pity in the eyes of my friends replaced with commendation – to work, produce, provide, and to feel that I have a place in the world – seeking no favors and given none – a MAN among MEN in spite of this physical handicap (*emphasis in original*)."<sup>67</sup> A "place in the world" derived from a sense of worth and employability, since, as one proponent of occupational therapy later put it, "the normal

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<sup>65</sup> Federal Board for Vocational Education in Cooperation with the Surgeon General's Office and the War-Risk Insurance Bureau, "To the Disabled Soldier and Sailor in the Hospital (Rehabilitation Joint Series), Monograph No. 1" November, 1918, 7. Ibid. Otis Historical Archives 245, Box 9, Folder: Legislation, etc. for O.T,

<sup>66</sup> Lieutenant-Colonel Harry E. Mock, "Curative Work," *Carry On* 1, no. 9 (June 1919): 15.

<sup>67</sup> "Cover Art," *Carry On* 1, no. 7 (April 1919). Both Beth Linker and Carol Byerly also cite this "Creed." Beth Linker, *War's Waste: Rehabilitation in World War I America* (Chicago, Illinois: University of Chicago Press, 2011). Carol R. Byerly, *Good Tuberculosis Men: The Army Medical Department's Struggle with Tuberculosis* (Washington, D.C.: Borden Institute, Forthcoming).

atmosphere of the average man is that of work activity, and the production of something masculine.”<sup>68</sup> Classifications of rehabilitation as a means by which to reclaim manhood were pervasive in the medical literature of the time. “The man who has lost his right hand and who learns to write with his left,” wrote Herbert J. Hall, “accomplishes more than he realizes, for he discovers that he is still a man.”<sup>69</sup>

Although occupational therapist Lena Hitchcock and her colleagues, like army brass, subscribed to prevailing conceptions of individual responsibility and manhood, by virtue of serving on wards daily, they acquired a less lofty view of the goals and prospective benefits of occupational therapy. “So far, none of our occupational therapy is orthopedically (*sic*) corrective,” Hitchcock reported while performing reconstruction work in France in 1919, “but at least it prevents the boys from drinking too much and losing all their money shooting craps.”<sup>70</sup>

Alberta Montgomery, who began working at Walter Reed as a reconstruction aide in August 1918 and served as the hospital’s director of occupational therapy from January 1922 through 1933, was likewise focused on the immediate mental benefits of OT.<sup>71</sup> Her notes on patient treatment in early 1919 document her assessment of various patients. Among her weekly observations: “work keeps him more quiet;” “work supplies a field for initiative and creative structural thought;” “work keeps him from thinking about his troubles;” “work makes him less restless;” “work makes him more ambitious;” “work makes him concentrate on plans for future;”

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<sup>68</sup> Louis J. Haas, *Occupational Therapy for the Mentally and Nervously Ill* (Milwaukee: The Bruce Publishing Company, 1925), 22.

<sup>69</sup> Hall, “Bedside and Wheel-Chair Occupations”: 9.

<sup>70</sup> Hitchcock, “The Great Adventure”, 51.

<sup>71</sup> For information on the career of Alberta Montgomery: Army Medical Center, “Data Pertaining to Service of Alberta Montgomery” June 6, 1933. Montgomery Collection, Otis Historical Archives 245, Box 9, Folder: Misc. Correspondence, National Museum of Health and Medicine, Washington, D.C.



“work makes him more contented;” “work keeps him happy - makes him forget his condition.”<sup>72</sup>

According to the assessments of Montgomery and Hitchcock, work through occupational therapy could spur character development and henceforth, industriousness.<sup>73</sup>



*“Occupational Therapist, Roberta Laughlin, of San Jose, Cal., shown with one of her patients” at Fort McHenry.<sup>74</sup>*

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<sup>72</sup> Alberta Montgomery, “Class Notebook” 1919. Montgomery Collection, Otis Historical Archives 245, Box 6, Folder: Class notebooks, National Museum of Health and Medicine, Washington, D.C. Alberta Montgomery, “Class Notebook” 1919, Ibid. Otis Historical Archives 245, Box 6, Folder: Class notebooks,

<sup>73</sup> Marina Larsson touches on the centrality of the mindset of soldiers in rehabilitation efforts. “In rehabilitation rhetoric,” she writes, “the ‘problem’ was not necessarily impairment, but rather the willingness or unwillingness of men to strive for productivity.” Marina Larsson, “Restoring the Spirit: The Rehabilitation of Disabled Soldiers in Australia after the Great War” *Health & History* 6, no. 2 (2004): 53.

<sup>74</sup> “Photo #18, Reconstruction Aide with Patient”, undated. Lynch Collection, Otis Historical Archives 220, Scrapbook, Occupational Therapy - photos of soldiers at Fort McHenry, 1918-1920, National Museum of Health and Medicine, Washington, D.C., Washington, D.C.

Some soldiers resisted rehabilitation tactics they viewed as militarized or irrational and refused to assume roles (from jewelry-maker to industrial wage-earner) prescribed for them. Many served in the army with a clear goal of capitalizing on benefits such as government-sponsored education. And that goal, at least sometimes, did not jibe with partaking in arts and crafts activities.

Although occupational and vocational training were both based on a general belief in the value of work therapy, soldiers themselves distinguished between different types of work. Lena Hitchcock reported as much from her occupational therapy post at a hospital in France. “Just as at Walter Reed,” she wrote, “the men were suspicious and scoffing – ‘women’s work’ – they called it.” Alberta Montgomery’s notebook is replete with accounts of soldiers who resisted participating in bedside activities like knitting and jewelry making. According to Montgomery, a soldier named Burns reported that he “does not want to do anything that would look, as he says, ‘the least bit feminine.’” So, he was assigned to “sawing and making equipment.” Merlin Meyhard, who was in the hospital with a gun shot wound to his left hand and had been crafting a cord belt during visits to the OT shop, told Montgomery that he preferred auto repair work. Jerome McGinn, also in the hospital with a gunshot wound and working on a cord belt, told the reconstruction aide he was more interested in schoolwork than occupational work. “Wants to complete his belt later -- is working on electricity now and is interested in that,” Montgomery noted of McGinn. Likewise, Montgomery reported that Verne Caldwell, hospitalized for a gunshot wound in his forearm, “wants to take full advantage of the opportunity for education offered by the government.” When Caldwell did partake in a cord belt project, Montgomery said, “he did this only to show someone else how and did not use the injured arm.” Instead, Caldwell

devoted his intellectual and physical efforts to drafting classes at the hospital.<sup>75</sup> He and many others, evidently, were interested in enhancing their own employability and industriousness, but on their own terms, and without going through what one scholar calls, “feminine and child-like recuperation” processes.<sup>76</sup>

James E. Russell, chief educational officer of the Division of Reconstruction for the Office of the Surgeon General, attempted to address this issue head on. Occupational therapy was meant, above all, he said, to be useful, – a feat that could be achieved through practitioners’ industriousness. “The criticism we have encountered,” Russell noted in a journal article, “is that this work of occupational therapy leads nowhere, that it does not provide a suitable job for a full-blooded man.” He urged occupational therapists to provide soldiers with “something worth doing, a real task instead of a play task.” This, Russell proposed, might lead to a lessening of hostility and mockery among soldiers. He made his plea in December 1918 with some earnestness: after all, the army had plans to call for 4,000 more reconstruction aides over the course of a year.<sup>77</sup>

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<sup>75</sup> Alberta Montgomery, "Class Notebook" 1919. Montgomery Collection, Otis Historical Archives 245, Box 6, Folder: Class notebooks, National Museum of Health and Medicine, Washington, D.C.

<sup>76</sup> The quote is from Ana Carden-Coyne, "Ungrateful Bodies: Rehabilitation, Resistance and Disabled American Veterans of the First World War " *European Review of History* 14, no. 4 (2007). Such resistance extended beyond hospital walls. Soldiers’ goals did not always mesh with government-sponsored vocational programs that funneled them into industries most in need of employees. As Scott Gelber points out in reference to vocational education for veterans following the war, “the clash between veterans' expectations and the bureaucracy's desire to maximize postwar economic efficiency plagued the reeducation program.” While soldiers sought training as skilled laborers even if they had previously worked unskilled jobs, the government vocational program often worked against them, using intelligence tests “rife with class, racial, and regional bias,” to justify limiting veterans’ employment opportunities. Scott Gelber, "A 'Hard-Boiled Order': The Reeducation of Disabled World War I Veterans in New York City," *Journal of Social History* 39, no. 1 (2005). Ana Carden-Coyne also points out, “disabled veterans conceptualized the idea of physical restoration more fully than government and rehabilitators did.” Carden-Coyne, "Ungrateful Bodies: Rehabilitation, Resistance and Disabled American Veterans of the First World War ": 543-4.

<sup>77</sup> James E. Russell, "Occupational Therapy in Military Hospitals (Article from American Journal of Care for Cripples)" December 1918, 112-16. Montgomery Collection, Accessed in Otis Historical Archives 245, Box 15, National Museum of Health and Medicine, Washington, D.C.

Various scholars have offered perspective on the proposed connection between masculinity and recovery efforts. Soldiers' rehabilitation following the Great War depended on their return to "full citizenship," according to Beth Linker, which was contingent on a definition of manhood based on both economic and social characteristics.<sup>78</sup> Roxanne Panchasi contextualizes postwar rehabilitation efforts in France as being emblematic of a larger striving for "rational management of the destructive and disordering effects of the war experience," and argues that the disabled soldier's body posed a quandary that could "confuse the boundaries between men and women." "The rehabilitation of the disabled soldier," she writes, was a "crucial site of the negotiation of (a) wartime and postwar 'crisis of masculinity.'"<sup>79</sup> According to Ana Carden-Coyne, the disabled male was seen not only as feminized, but as infantilized as well. Rehabilitation through occupational therapy, she argues, could be thought of as "an active process of returning men from an inert state... especially by undertaking feminine and 'kindergarten' tasks, such as knitting, beadwork and basket weaving ('for mother'), through to 'some more masculine and practical occupation,' which involved operating industrial machines, or other mechanic activities..."<sup>80</sup> Such an assessment helps place the diverse educational offerings at Walter Reed into perspective.

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<sup>78</sup> Beth Linker, "For Life and Limb: The Reconstruction of a Nation and Its Disabled Soldiers in World War I America" (PhD, Yale University, 2006), 96.

<sup>79</sup> Roxanne Panchasi, "Reconstructions: Prosthetics and the Rehabilitation of the Male Body in World War I France," *Differences: A Journal of Feminist Cultural Studies* 7, no. 3 (1991): 110-12.

<sup>80</sup> Carden-Coyne, "Ungrateful Bodies: Rehabilitation, Resistance and Disabled American Veterans of the First World War": 548. Also see Joanna Bourke, *Dismembering the Male: Men's Bodies, Britain, and the Great War* (Chicago: University of Chicago Press, 1996).

### Practitioners and patients

Less central to scholarly studies has been the popular distinction between worthy and unworthy soldiers. During World War I, disabled soldiers and army doctors evaluated each other and came up with mixed reviews. Although there were vast differences in their educational and cultural backgrounds, doctors, nurses, and patients who encountered each other in hospitals abroad reported feeling great respect for one another. In U.S. hospitals, however, where patients who had never left the country were treated for non-battle injuries, judgments were sometimes less favorable.

Contrasting with the doctors and army higher-ups who devised rehabilitation programs, the majority of wounded veterans of World War I had left school between fifth and seventh grade and 25 percent were illiterate. The rate reflected that of the army in general: according to results of army intelligence tests, 21.5 percent of all white troops and 50.6 percent of all black troops were officially illiterate.<sup>81</sup> As Grace Harper, chief of the Bureau of Reconstruction and Re-education of the American Red Cross put it, “Many wounded men are somewhat like children.” In rehabilitation efforts, she said, “ignorance is our stumbling block.”<sup>82</sup>

Soldiers, for their part, passed their own judgments of caregivers. Joseph W. Bubendorf reported having polar experiences at a hospital in the U.S. and a hospital in France. He recalled seeking treatment for an abscess that had formed on his hand after a fall at Camp Merritt in New Jersey in the winter of 1918: “They had medical inspection once a day at 5pm and the officer in charge, if you could call him such – stuck his head in the door and called – ‘is everybody all

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<sup>81</sup> Keene, *Doughboys, the Great War, and the Remaking of America*, 28.

<sup>82</sup> Grace Harper, "Re-Education from the Point of View of the Disabled Soldier (Article from American Journal of Care for Cripples)", 85-7. Montgomery Collection, Otis Historical Archives 245, Box 15, National Museum of Health and Medicine, Washington, D.C.

right?’ hoping he would have nothing to do – so I called out – ‘no – I need attention’ so he pulled out his jack knife and drained the abscess with no sign of a dressing. I recovered eventually.”

Bubendorf’s impressions of services at Camp Merritt differed sharply from his experience working at a hospital in France, where, he said, injured patients were given hot showers and treated with great care.<sup>83</sup> John V. Hawley, who served as a Cook in a convalescent hospital in France referred to the doctors he worked alongside, as “gentlemen.” They were “dedicated” to the cause, he said, and some were “family men that left a fine practice to help out when their country needed them. THEY WERE TOPS (*emphasis in original*).”<sup>84</sup>

Bubendorf’s suggestion that doctors abroad were more highly qualified than those who served in the U.S. was seconded by Paul B. Magnuson, an orthopedic surgeon assigned to the Surgeon General’s office during the war to “get men (who were doctors) and put them in the position in which we thought they would best serve.” When Magnuson began his work in the fall of 1917 and tried to find medical professionals to staff domestic hospitals, he realized that, “most of the best ones had gone into the Army early; some had been ordered overseas at their own request, so the pickings were pretty slim by this time...”<sup>85</sup>

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<sup>83</sup> Joseph W. Bubendorf, "Army Services Experience Questionnaire". World War I Veterans Survey, Medical Department, Camp Hospital, Field Hospital, General Hospital, Army Heritage and Education Center, U.S. Military History Institute Archives, Carlisle Barracks, Carlisle, Pennsylvania.

<sup>84</sup> John V. Hawley, "Army Service Experiences Questionnaire, 1914-1921". World War I Veterans' Survey, Medical Department, Camp Hospital, Field Hospital, General Hospital, Army Heritage and Education Center, U.S. Military History Institute Archives, Carlisle Barracks, Carlisle, Pennsylvania. Hawley’s impression that a doctor was not quite “a military man” confirms Carol Byerly’s stance that medical officers during World War I occupied a “unique position... between the government and its citizenry.” As physicians, Byerly writes, “they were committed to the health of each individual, but as soldiers they were duty-bound to the nation’s war aims and therefore charged with preparing young men to fight and perhaps die en masse for their country.” Carol R. Byerly, *Fever of War: The Influenza Epidemic in the U.S. Army During World War I* (New York: New York University Press, 2005), 9.

<sup>85</sup> Paul B. Magnuson, *Ring the Night Bell* (Birmingham, Alabama: University of Alabama School of Medicine with permission from Little Brown and Company, 1986 (originally published in 1960)), 163.

As troops judged medical personnel, doctors and other caregivers shared perspectives about soldiers. Many reported being overwhelmed by the heroism and grace of their patients in the face of almost incomprehensible physical and mental challenges. "I wish you could accompany me through my wards on any old morning and see these boys paying the price of war without any brass bands or speeches to cheer them on, yet doing it gladly and without complaint," wrote New York surgeon Condict Cutler to a colleague in June 1918 from a field hospital in France.<sup>86</sup> Cutler further reported having a tremendous "admiration for their spirit," and a desire to "do everything I can for all my patients."<sup>87</sup> Arthur Purdy Stout, a professor of pathology at Columbia University and army volunteer in France, had similar feelings of empathy for his patients. "It is particularly hard to see the wounded die," he wrote in his diary. The dead and wounded, he said, were "fine lads who started out so bravely to this land of France and have to leave so many loved ones behind."<sup>88</sup> Rustin McIntosh, a Pediatrician at Columbia-Presbyterian Hospital who volunteered with the army in France, was grateful for the friendly attitude of his underlings. "I am getting more accustomed to giving orders and handling the men," he wrote to his family in March 1918. "They're such darn good fellows that it's much easier than it might be; they always interpret things with charity and give you the benefit of the doubt."<sup>89</sup> Nurse Nettie Trax, who also served in a hospital in France, reported that her soldier-patients were "absurdly

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<sup>86</sup> "Letter from Condict Cutler to H.C. Beckman", July 30, 1918. Condict W. Cutler Papers, 1918-ca.1952, Box 1, Cutler, Condict W., Jr. To H.C. Beckman, France, 30 July 1918, Columbia University Libraries, Rare Book and Manuscript Library Collections, New York, New York.

<sup>87</sup> "Letter from Condict Cutler to H.C. Beckman", August 22, 1918. Condict W. Cutler Papers, 1918-ca.1952, Box 1, Cutler, Condict W., Jr. To H.C. Beckman, France, 30 July 1918, Columbia University Libraries, Rare Book and Manuscript Library Collections, New York, New York.

<sup>88</sup> Arthur Purdy Stout, "War Diary" July 24, 1918. Papers of Arthur Purdy Stout, 1885-1985, Box 3, Folder #8: War Diary, July 4 - July 25, 1918, Columbia University Medical Center Archives, New York, New York.

<sup>89</sup> Rustin McIntosh, "Letter from Rustin McIntosh to His Family" March 29, 1918. Papers of Rustin McIntosh, Box 4, Folder: Letters to family while oversea, Columbia University Medical Center Archives, New York, New York.

grateful.” “Never before have I felt a sense of achievement nor felt that my own bit of work was worth something to somebody,” Trax said. “But it is here.”<sup>90</sup>

Tensions arose, however, when injuries and illnesses were not the result of battle. When army higher-ups and medical practitioners faced complicated questions regarding treatment and rehabilitation for soldiers who had never left the U.S., impressions of heroism were replaced by more tenuous opinions. Between April 1917 and December 1918, the Army Medical Department added about 2.57 million patients to the sick report. 2.4 million of them were serving in the U.S., while 873,816 were serving abroad.<sup>91</sup> A March 1918 *Military Surgeon* article submitted by the Army Surgeon General’s office expressed concern with this massive number of cases. It cited an army doctor’s contention that ten percent of those reporting to sick call and the camp dispensary were “pure malingering,” while “40 percent exaggerate symptoms, which would not be sufficient to cause a cessation of work in civil life, (and) 40 percent (were) somewhat sick and would stop work in civil life, but would not send for a doctor.” That left only ten percent who were “quite in need of attention and in civil life would stop work and procure medical attendance.” In order to eliminate waste and determine if a recruit was being truthful about his condition, doctors were encouraged to ask and ponder a litany of questions about his work, family, and personal life. Without indicating that the soldier was “under suspicion,” doctors should try to ascertain how successful he was prior to service in school and at work. Had he deserted wives and children? Had he been a “good mixer” or was he “solitary, secretive, and morose?” Did he “bear grudges” against people? What did other people think and say of him? Did he “think the world a good

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<sup>90</sup> "Letter from Nettie Trax to Mother", September 22, 1917. Veterans History Project Collection, Papers of Nettie Trax, ID 55632, American Folklife Center, Library of Congress, Washington, D.C.

<sup>91</sup> In the U.S., patients spent an average of 20 days in the hospital; ill and wounded soldiers treated abroad spent about 27 days in military hospitals. Love, "A Brief Summary of the Vital Statistics of the U.S. Army During the World War."



place to live and enjoy?” What were his “views as to war and the rights of the individual?” A patient’s answers to such questions, the article said, “will often flatly contradict the possibility that his present claims are genuine.” As many troops as possible should be kept out of hospitals, the Surgeon General’s Office article noted, but those admitted who might be feigning their maladies, should not be told exactly *why* they were admitted, and could be offered a “light diet” and “disagreeable medications.” Additionally, “anesthetics for diagnostic purposes are frequently given, as, during semi-consciousness, the patient often says things which contradict previous statements.” Hospital stays of supposed malingerers could also be made less pleasant and thus limited, the article said, if “visits of family and friends were discouraged,” and if the soldier-patient was “confined to his quarters when not on duty.”<sup>92</sup> Such drastic measures gave a great deal of power and autonomy to medical officers.

At Walter Reed, many of the approximately 14,000 patients treated in 1918 had supposedly non-heroic injuries and illnesses, and a relatively small number were discharged with a disability incurred in the line of duty. More than 1,500 patients admitted to the hospital in 1918 were treated for influenza. The large majority of patients who received care at the hospital that year – 10,376 officers and enlisted men – were returned to duty. Another 866 patients were transferred to other hospitals. Of the 688 discharged due to disability, 198 were reported to have incurred their injuries or illnesses in the line of duty, the majority of which were listed as “injuries and diseases of organs of locomotion.” (Some of the 597 soldiers fitted with prosthetic limbs at Walter Reed in 1918 were likely included in that number.) Other major causes of discharge due to disability were tuberculosis (22 cases total discharged, 20 of whom were said not to have incurred the disability in the line of duty), and “mental deficiency, moron” (26 cases

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<sup>92</sup> U.S. Army Office of the Surgeon General, "Malingering in U.S. Troops, Home Forces, 1917," Ibid. Vol. XLII, Numer 3 (March 1918).

discharged, 24 not incurred in the line of duty). At least 24 conditions listed as eligible for discharge from Walter Reed Hospital in 1918 pertained to mental illness, including “mental deficiency, imbecile,” (seven discharges total, none incurred in the line of duty), “constitutional psychopathic state, emotional instability” (eight cases discharged, none incurred in line of duty).<sup>93</sup> The listed conditions indicate the types of medical issues that would necessitate treatment following the war.

Many army officials, meanwhile, deemed these troops sorry embodiments of long-term health threats less likely than gun shot wounds and amputations to be alleviated by rehabilitation. The 1921 Surgeon General’s report quoted base commanders, who lamented, “‘Never in the history of the army has its ranks been filled with such poor physical specimens and such young lads so susceptible to disease.’” They postulated that, “a large majority of cases... have disabilities which existed prior to enlistment, and a number... have been previously discharged from the military service with the same disability.” Ultimately, these commanders concluded, “it would seem that a great deal of laxity existed in the recruiting system which permitted the enlistment of these men.”<sup>94</sup>

In an address before the National Society for the Promotion of Occupational Therapy in November 1918, James E. Russell, chief educational officer of the Division of Reconstruction for the Office of the Surgeon General, concurred. Alleging that many soldiers in military hospitals were predisposed to tuberculosis and heart conditions – “weaklings and not soldiers” –

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<sup>93</sup> "Walter Reed Army General Hospital Annual Report for 1918". On the challenge the influenza pandemic posed to the army, see Byerly, *Fever of War: The Influenza Epidemic in the U.S. Army During World War I*.

<sup>94</sup> Annual Report of the Surgeon General to the Secretary of War, 1921, (Washington, DC.: Government Printing Office, 1921), 11.

Russell argued, “some of these men are not worthy of the efforts being expended upon them.”

Men “who were just no good and never will be any good,” he said, were “hardly worth saving.”<sup>95</sup>

On the other hand, Russell noted, there was another type of patient – the soldier wounded heroically overseas. Such “full-blooded men” were “only slightly weakened by their wounds; their disabilities are of a kind that do not tend to break them down physically, maybe an amputation of one leg, maybe an arm off, maybe the loss of sight or hearing or any other accident that may come to any individual leaving him still strong and physically fit to work if the right work can be found.”<sup>96</sup>

Russell’s ideas about “full-bloodedness” were firmly rooted in the contemporary understanding of disability. As Philip Longmore notes, when the United States entered World War I, disability was seen as “a defect residing in the individual and therefore requiring individual medical rehabilitation, special education, and vocational training to improve employment prospects.”<sup>97</sup> Marina Larsson concurs, noting that there is “consensus among historians that at the beginning of the twentieth century, disability became understood as a problem the individual could rise above through psychological adjustment, rather than a condition that entailed inevitable physical limitations, suffering and dependence.”<sup>98</sup> In fact, some

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<sup>95</sup> Russell, “Occupational Therapy in Military Hospitals (Article from American Journal of Care for Cripples)”, 112-16.

<sup>96</sup> Ibid.

<sup>97</sup> Paul K. Longmore, *Why I Burned My Book and Other Essays on Disability* (Philadelphia: Temple University Press, 2003), 49.

<sup>98</sup> Larsson, “Restoring the Spirit: The Rehabilitation of Disabled Soldiers in Australia after the Great War”: 49. Changing notions of disability in this era were also reflected by the fact that industrial accidents and disease were being transformed not only into problems that could be solved, but also into problems to be dealt with on a societal level. See Chapter One, p. 37-8, for a discussion of the rise of workers’ compensation laws in the years surrounding World War I. For general information on a related increasing focus on workplace safety, see Mark Aldrich, *Safety First: Technology, Labor, and Business in the Building of American Work Safety, 1870-1939* (Baltimore, Maryland: Johns Hopkins University Press, 1997).

advocates of the time recognized the potential for the war, and the wounded soldiers left in its wake, to “educate the public about disability.”<sup>99</sup>

### Race in the wards

Soldiers’ rehabilitation experiences depended not only on preconceived notions about gender and disability, but also about race. More than 13 percent of soldiers serving in the United States Army during World War I were African American.<sup>100</sup> Official army policy dictated that medical and military efficiency would be prioritized above all else, and that white and black soldiers would be treated in the same wards according to their ailments, not according to race. But in at least some domestic army hospitals, in the face of rising social tensions, army higher-ups made exceptions to the rule.

In some wards and classrooms of Walter Reed, integration was more widely practiced than it was at other facilities. One photo depicting the hospital’s rehabilitation efforts shows a black soldier at a rug-weaving loom. Another depicts a group of five wounded soldiers – two of them black – posed on the porch of a hospital building. They look into the camera, their residual limbs displayed. White therapists are featured in the photo as well, one of them with her hand resting on one of the black soldiers’ legs.

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<sup>99</sup> Carden-Coyne, "Ungrateful Bodies: Rehabilitation, Resistance and Disabled American Veterans of the First World War ": 547.

<sup>100</sup> More than 360,000 African Americans served in all, in addition to 9,430 Filipinos, 15,101 “Porto Ricans,” and 9,497 Hawaiians, according to Love, "A Brief Summary of the Vital Statistics of the U.S. Army During the World War." In total, more than 18 percent of troops serving during World War I were foreign-born. Nancy Gentile Ford argues that the War Department “turned to Progressive reformers and ethnic leaders to help... in training, educating, Americanizing, socializing, and bolstering the morale of (foreign-born) men.” Nancy Gentile Ford, *Americans All! Foreign Born Soldiers in World War I* (College Station: Texas A&M University Press, 2001), 13. According to Lucy Salyer, 123,277 of those inducted in the first draft of 1917 were “aliens;” 76,545 of those “had not declared their intent to become citizens or were enemy aliens and thus technically exempt from conscription.” Lucy E. Salyer, "Baptism by Fire: Race, Military Service, and U.S. Citizenship Policy, 1918-1935," *The Journal of American History* Vol. 91, no. No. 3 (December 2004): 852.



*"W.R.G.H. Artificial Limbs, massaging of stumps preparatory to fitting"*<sup>101</sup>

Alice Duffield, a white nurse who spent the bulk of her wartime service treating young black soldiers diagnosed with pneumonia at Camp Pike in Little Rock, Arkansas, shrugged off the suggestion that, as a working class southern white woman, she would have thought anything of bathing and taking the temperatures of African American soldiers. "Didn't bother me," Duffield said in an oral history interview recorded more than 70 years after the war. Family and friends "never said one thing about it," she maintained. "It was just nursing, that was all there was to it."<sup>102</sup> Duffield's impressions paint a somewhat innocuous picture of a time when some

<sup>101</sup> Accessed in Unsorted Files, Public Affairs Office, Walter Reed Army Medical Center, Courtesy of United States Army/Walter Reed Army Medical Center, Sherman Fleek, Lt. Col. US Army (Ret.). (Copy available from author.) On World War I medical photography, see Beth Linker, "Shooting Disabled Soldiers: Medicine and Photography in World War I America," *Journal of the History of Medicine and Allied Sciences* Vol. 66, no. No. 3 (July 2011).

<sup>102</sup> "Oral History Interview with Alice (Mikel) Duffield. Interviewer: Linda Barnickel", Recorded March 4, 2002. Veterans History Project Collection, Papers of Alice Duffield, ID 1747, American Folklife Center, Library of Congress, Washington, D.C.

southern states had laws on the books stipulating that white nurses could refuse to treat black patients.<sup>103</sup>

While white nurses like Alice Duffield might be tasked with treating black patients, they did not live alongside their African American nurse colleagues. Aileen Stewart, one of approximately 1,800 black nurses certified by the Red Cross to serve with the army during World War I, reported that there was virtually no interaction between white and black nurses at Camp Sherman in Ohio. After graduating from nursing school at the Freedmen's Hospital in Washington, D.C. in 1917, she was barred from assuming a post as an army nurse, but was recruited by the Red Cross to treat West Virginia miners during the 1918 flu epidemic. Only after peace was declared did the army open its doors to nurses of color.<sup>104</sup> Two weeks after the Armistice in November 1918, Stewart and her classmates received a letter from the Army Surgeon General's Office offering them long-awaited positions as army nurses. One of the first African American women nurses to receive a commission, Stewart was sent with her cohort to Camp Sherman. There, she later recalled, "We were assigned to 'separate but equal' living quarters on the base, which was the accepted system of segregated living." The home had ten bedrooms, showers, a living room, dining room, and kitchen, and, Stewart recalled, "we had a full-time Negro maid who prepared our meals and served them to us in our own dining room."<sup>105</sup>

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<sup>103</sup> On controversy surrounding such a law in Alabama, see Jennifer D. Keene, "The Long Journey Home: Federal Veterans' Policy and African American Veterans of World War I," in *Veterans' Policies, Veterans' Politics: New Perspectives on Veterans in the Modern United States*, ed. Stephen Ortiz (Gainesville, Florida: University Press of Florida, 2012).

<sup>104</sup> All nurses served without military rank – as civilian "contract nurses" – until February 1901, when the Army Nurse Corps was created. Black women were not eligible to serve as army nurses until late 1918, when the flu epidemic and the demands of demobilization led the Army Surgeon General's Office to re-consider the whites-only policy.

<sup>105</sup> Aileen Cole Stewart, "Ready to Serve," *The American Journal of Nursing* Vol. 63, No. 9(September 1963).

The segregation ““didn’t seem a big thing”” Stewart said. “Of course, we didn’t know enough to be offended. We made our own social life, didn’t socialize with the white nurses.””<sup>106</sup>

Medical treatment of soldiers, in fact, posed a distinct challenge to the United States army’s official policy of racial segregation, which remained in place through 1948. Hospital wards were different from staff quarters and army camps, where the military worked diligently to maintain segregated units and living spaces. Upholding the policy of separate quarters for black and white soldiers in health facilities was simply untenable, according to Colonel D.W. Ketcham of the War Plans Division. “In hospitals, patients have to be classified by diseases rather than with reference to other considerations,” he said, “and moreover, while men are sick in bed there is scarcely any opportunity for friction due to race troubles.”<sup>107</sup> Thus, during the Great War, hospital wards and occupational therapy workshops provided a brief foray into racial integration for at least some soldiers and caregivers. The fact that stated policy pertaining to military hospitals was integration, not segregation, as it was in civilian (and, in the near future, veterans’) hospitals, corresponds with the notion that military medicine was based, first and foremost, on military efficiency.

Some white soldiers were jarred by and hostile to the experience of integration. James Cunningham believed his assignment to the mental ward at Walter Reed qualified as an inexplicable punishment, not least of all because of who he found himself surrounded by: “I am

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<sup>106</sup> ———, “Interview Transcript, Undated”. World War I Veterans Survey, Army Nurse Corps, Continental, Army Heritage and Education Center, U.S. Military History Institute Archives, Carlisle Barracks, Carlisle, Pennsylvania. “Colored nurses’ quarters” at Camp Grant in Illinois were, according to army reports, “excellent,” and furthermore, “met all requirements.” Weed, *Medical Department of the United States Army in the World War; Volume 5: Military Hospitals in the United States*, 200. For more on Stewart and African American nurses in the World War, see Gavin, *American Women in World War I: They Also Served*, 59-61.

<sup>107</sup> Cited in: Keene, *Doughboys, the Great War, and the Remaking of America*, 90. For a general source on segregation in military hospitals, see Robert J. Parks, “The Development of Segregation in Us Army Hospitals, 1940- 1942,” *Military Affairs* Vol. 37, No. 4(December 1973).

not restricted to this ward (Ward X) as yet and I hope I won't (be) with your kind assistance," Cunningham wrote to the wife of a Marine Corps Colonel in July 1918. "It will kill me if I am as I think nearly all in the ward are crazy and (50%) fifty percent of the Patients are Negroes."<sup>108</sup> Cunningham's claim was based on the contemporary realities of medical treatment. As Vanessa Northington Gamble notes, in the civilian world and especially in the South, black patients were often admitted to mental institutions rather than general hospitals, so that they might be kept separate and apart from the majority of fully cognizant white patients. If administrators of Southern hospitals did allow African Americans to enter majority-white facilities, they were often relegated to separate wards and offered inferior care.<sup>109</sup> It made sense then, for Cunningham to assume that if he found himself among black patients, he must be receiving substandard treatment.

The Inspector General duly undertook an investigation of Cunningham's sundry claims, including the one, in the words of the ensuing report, "that he was transferred from Ward 41 to 43 (formerly called X) and placed among crazy negroes (*sic*) as punishment." Ultimately, the Inspector General's report concluded not only that Cunningham was receiving proper treatment, but also reiterated Col. Ketcham's point in no uncertain terms: "It is customary to treat white and colored soldiers in the same wards at this hospital."<sup>110</sup>

Although it may have been "customary" to treat black and white soldiers in the same wards at Walter Reed and other institutions, segregation was practiced throughout the war at

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<sup>108</sup> James Cunningham, "Letter to Mrs. B.R. Russell" 1918. RG 159, Box 1109, Folder 6, National Archives and Records Administration, Washington, DC.

<sup>109</sup> Vanessa Northington Gamble, *Making a Place for Ourselves: The Black Hospital Movement 1920-1945* (New York; Oxford: Oxford University Press, 1995), 73.

<sup>110</sup> C.S. Hamilton, "Inspector General's Department Report of the Alleged Mistreatment of Private James Cunningham, Company "G" " 1918. Office of the Inspector General Correspondence, 1917-1934, RG 159, Box 1109, Folder 6, National Archives and Records Administration, Washington, DC.



numerous hospitals. When the mother of a black soldier complained about “discrimination against the colored soldiers” at Army General Hospital No. 9 in Lakewood, New Jersey, Winford H. Smith of the Surgeon General’s Office responded that the Commanding Officer of the facility had been instructed to ensure that ““colored soldiers are to be given the same attention in the service of meals as is given to the white soldiers.”” Smith further explained:

Over a year ago evidence of considerable friction developed in many of the hospitals particularly in the south, and numerous complaints were received because of the indiscriminate mixing of colored and white patients in the same wards. After careful consideration, and believing it to be in the interest of harmony and to the advantage of the colored soldiers quite as much as to the white, instructions were issued from this office to the effect that so far as practicable, the colored soldiers would be placed in wards by themselves, but that they would receive the same careful consideration in every detail as was accorded any other soldiers. Wherever colored soldiers were patients in the hospital in sufficient number to warrant their being placed in separate wards, this was done.<sup>111</sup>

Carol Byerly points out that Army Surgeon General Gorgas officially approved a policy of segregation for hospitals in both the north and south in March 1919, ““in the best interest of all concerned”” and ““so far as possible.”” At General Hospital No. 8 in Otisville, New York, education and rehabilitation courses were segregated, with black soldiers receiving instruction in their segregated wards, rather than in classrooms.<sup>112</sup>

Although Smith of the Surgeon General’s Office maintained that there “has been no less vigilance in the care and treatment of the colored soldiers,” there were plenty of reports that African Americans encountered hostility in military hospitals, not least of all from fellow patients who were white. In the fall of 1918, two black privates at the Mineola base hospital in New York complained to local Urban League officials that a fellow African American soldier,

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<sup>111</sup> "Wounded Soldiers Are Segregated," *The Baltimore Afro-American* January 17, 1919.

<sup>112</sup> Byerly, *Good Tuberculosis Men: The Army Medical Department's Struggle with Tuberculosis*.

Charles Parker, was “unmercifully beaten up by white privates from the south because he would not give his place during mess time to some white soldiers who came after him and would not get in at the end of the line.” Private Parker, his peers said, would likely lose sight in one of his eyes as a result of being “attacked with white soldiers’ knives and forks which they had for eating purposes.” The soldiers suspected of aggression were being held under arrest by the army, but the allegations were difficult to prove since, “none of them will disclose the guilty ones among their number,” according to *The Chicago Defender*. The soldiers who reported the occurrence to Urban League officials said they were hesitant to return to camp, “and one was so downhearted that he actually shed tears,” disappointed in a “government that cannot protect its own soldiers from the ‘crackers,’ as he phrased it.”<sup>113</sup> *The Defender* later referred to complaints about “segregation and discrimination of the vilest sort” and hospital “treatment... below the standard of human endurance” as “an obvious example of a country’s crime against a race that has always shed its blood that this nation might occupy the exalted place in the world of today which is now does.”<sup>114</sup>

Efforts abounded in the African American community to provide for ill and injured black soldiers by protecting them from such injustices, celebrating their wartime efforts, and offering social options. The Circle of Negro War Relief “constituted the nearest approach to a Red Cross... through which the colored people cooperated during the war.”<sup>115</sup> According to a leader of the organization, the group was founded in New York in November 1917 “with the idea of

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<sup>113</sup> “Soldiers Unmercifully Clubbed by Southerners at Hospital,” *The Chicago Defender* November 2, 1918.

<sup>114</sup> “Soldier Complains of Inhuman Treatment,” *The Chicago Defender* August 2, 1919.

<sup>115</sup> Alice Dunbar-Nelson, “Chapter XXvii: Negro Women in War Work,” in *Scott's Official History of the American Negro in the World War*, ed. Emmett J. Scott (Chicago, Illinois: Homewood Press, 1919). See, for example, “Church Sends Care Packages to Soldiers in Drexel Ave Hospital,” *The Chicago Defender* January 3, 1920.

having the colored women of America, and some men, too... do as much as they possibly could for the colored soldiers.” Within a few months, similar groups arose in locales “extending from New York to Utah and throughout the New England states as far south as Florida.” By 1920, 60 groups of 25 members or more throughout the United States were affiliated with the Circle of Negro War Relief. The groups “did just what other war organizations did,” according to its leaders: they arranged visits to soldiers in the hospital with baked goods and handmade knits, and sponsored lectures and events. And they attempted to ensure that black soldiers and veterans had social options beyond segregated military camps and tension-filled hospital wards.<sup>116</sup> In Baltimore, for example, the War Camp Community Club for Colored Soldiers reserved a church Hall so that “soldiers and sailors (could) spend their brief furloughs in moral surroundings and away from dens of vice.” The club featured a reading room, cafeteria, billiard hall, writing room, and sleeping quarters.<sup>117</sup> The high demand for such services was confirmed by the fact that within just a few weeks, the hall was overcrowded, and the club was appealing to residents of the city to help house soldiers and veterans.<sup>118</sup> The Baltimore War Camp Club remained active throughout the fall of 1918, hosting meetings of “mothers” and “sisters” connected to the war effort.<sup>119</sup>

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<sup>116</sup>By 1920, Circle of War Relief leaders were attempting to ensure that the group was understood as more than just a wartime organization. They lobbied for an official affiliation with the Red Cross that would allow Circle member groups to assist with the “public health work among the colored people of the Country.” “Conference between Mrs. Noyes, Miss Fox, Miss Vande Verde and Miss Holmes of the Public Health Service, American Red Cross, and Mrs. Boutte and Mrs. Thoms of the Circle of Negro Relief (*Sic*), New York City”, February 18, 1920. Records of the American National Red Cross, Record Group 200, Box 45, Folder: 041, Circle for Negro War Relief, Inc., National Archives and Records Association, College Park, Maryland.

<sup>117</sup> “St. Mary's Hall Secured for Colored Soldiers When Visiting the City,” *The Afro-American* July 19, 1918. “St. Mary's Hall Secured for Colored Soldiers When Visiting the City.”

<sup>118</sup> “Soldiers Overcrowd 'Hotel' at St. Mary's,” *Afro-American* August 9, 1918.

<sup>119</sup> “War Mothers of Baltimore Meet Thursday at War Camp Community Services Club,” *The Afro-American* October 25, 1918. “Community Club Crowded with Soldiers,” *The Afro-American* November 8, 1918. The enthusiastic support for troops had evidently calmed by 1922, when one newspaper article declared that troops at

The African American social halls were a world away from the hostile environments of military and government hospitals, and were embraced by government officials eager to see feelings of patriotism ignited in the black community. At the opening of a club for black soldiers in Rockford, Illinois, doctor George C. Hall noted the importance of contributions of African Americans to the war effort. They represented “true Americanism,” according to Hall. “All races were giving their lives and their treasures,” he said, “that the benefits coming as the result of this tremendous sacrifice should know no person by race, creed or religion.”<sup>120</sup> In the summer of 1918, the federal government’s Committee on Women’s Defense Work authorized African American educator, Alice Dunbar Nelson, to visit various southern cities to ascertain whether a national council of black women might be organized. By officially sanctioning local efforts and bringing them into the fold of the government, officials felt they could “ensure a degree of cooperation and coordination with the least likelihood of upsetting existing social relations.”<sup>121</sup>

#### *The OT recruits and women’s professional advancement via the military*

The military tried but failed to recruit both military and civilian men as teachers in newly established reconstruction programs at hospitals like Walter Reed. But the men lacked teaching experience, and were also unwilling to accept the paltry salaries that came along with such work; according to an information sheet for a Civil Service examination for occupational therapy aides, starting salaries were \$1,680 per year, approximately \$600 less than the average salary of a

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Fort McHenry were “lonely... and wish that colored men and women living in the city would come down frequently and give them an entertainment of some kind.” “Wounded Men Still at Fort Mchenry,” *The Baltimore Afro-American* April 21, 1922.

<sup>120</sup> “Colored Soldiers’ Club Opens in Rockford near Camp Grant,” *Chicago Defender* August 17, 1918.

<sup>121</sup> William J. Breen, “Black Women and the Great War: Mobilization and Reform in the South” *The Journal of Southern History* Vol. 44, No. 3(August 1978).

bricklayer, painter or plumber.<sup>122</sup> In fact, the army had traditionally turned to females as personnel of last resort – even in caregiving capacities; during the Spanish-American War, it attempted to recruit 6,000 males to care for troops in camps infected with typhoid. When those efforts proved in vain, the military turned to recruiting women, signing up more than 1,500 of 2,500 applicants.<sup>123</sup>

General Joel E. Goldthwait, chief of orthopedics at Massachusetts General Hospital, and others – notably Elizabeth Upham Davis of the Federal Board for Vocational Rehabilitation, who had initiated courses in ‘invalid occupations’ at Milwaukee-Downer College in Wisconsin – promoted the idea of the involvement of women occupational therapists in soldiers’ recovery programs during and after World War I.<sup>124</sup> Stated qualifications for the job were based both on academic prowess and personal grace, though most publications emphasized the latter. “A young woman entering the profession should be a person of both academic and manual ability,” one pamphlet said. “She should possess tact – initiative – a strong sense of responsibility – good poise – a good sense of humor – excellent physical health and emotional stability.”<sup>125</sup> Another pamphlet, entitled, “Opportunities in Occupational Therapy,” stipulated that the prospective therapist “must be patient and cheerful and like to work with people.” She should also possess

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<sup>122</sup> The exam was offered in 1925, so salaries during the war were likely even lower. In 1925, the average annual salary for various union occupations in Chicago, including bricklayer, painter, plumber, stonecutter, and typesetter, was \$2,288. Robert VanGiezen and Albert E. Schwenk, "Compensation from before World War I through the Great Depression," *Compensation and Working Conditions, Bureau of Labor Statistics* (Fall 2001). "United States Civil Service Examinations: Occupational Therapy Aide; Occupational Therapy Pupil Aide", 1925. Montgomery Collection, Otis Historical Archives 245, Box 9, Folder: General Correspondence, National Museum of Health and Medicine, Washington, D.C.

<sup>123</sup> Mercedes H. Graf, "Women Nurses in the Spanish-American War," *Minerva* 19, no. 1 (2001).

<sup>124</sup> Quiroga, *Occupational Therapy: The First 30 Years, 1900 to 1930*, 151-9.

<sup>125</sup> "The Growing Use of Occupational Therapy", 5. Montgomery Collection, Otis Historical Archives 245, Box 1, National Museum of Health and Medicine, Washington, D.C.

some artistic ability, like to work with her hands, and be between the ages of 21 and 50 years old. “Other personal qualities which are most desirable,” the pamphlet continued, “are tact, resourcefulness, a sympathetic attitude, and a love for the work.”<sup>126</sup> Herbert J. Hall elaborated on those points in a February 1919 article. Calling on “women of the right qualifications to aid materially in a very important war work,” he asked that applicants have not only “a reasonable cleverness in acquiring the technique of simple handiwork,” but also “suitable personality.” The latter, he implied was more complicated than artistic ability: “It cannot be acquired.” Hall went on to convey the gravity of the duties of an occupational therapist. “It is a serious business, this good start on the right road for the crippled soldier,” he said. “If the work is made a joke or a kindergarten exercise, then bedside occupations will do more harm than good.” At the same time, Hall argued that aides should avoid a “a too-technical or matter-of-fact approach. My feeling,” he noted “is that the young woman who is to succeed in this work must have that subtle possession we call tact; also she must have charm and appeal; in short, an attractive personality.”<sup>127</sup>

Part of a larger contemporary wave of “well-educated daughters of the middle class” who sought to capitalize on wartime professional opportunities, both Lena Hitchcock and Alberta Montgomery answered the army’s call for reconstruction aides.<sup>128</sup> The first decades of the twentieth century, when women began working their way into the army in significant numbers, was a transitional moment for the world of women’s work. For the first time, according to Alice

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<sup>126</sup> Charlene Chalaron, “Opportunities in Occupational Therapy, Vocational Information Monographs, Number 16” 1932, 1-4. Ibid. Otis Historical Archives 245, Box 1, Folder: Medical History Book Notes Washington, D.C.

<sup>127</sup> Hall, “Bedside and Wheel-Chair Occupations”: 12.

<sup>128</sup> On women’s work, see Alice Kessler-Harris, *Out to Work: A History of Wage-Earning Women in the United States* (New York, Oxford: Oxford University Press, 1982), 218. On women’s multi-faceted motivations for joining the war efforts, see Kimberly Jensen, *Mobilizing Minerva: American Women in the First World War* (Urbana, Illinois: University of Illinois Press, 2008).

Kessler-Harris, “To aspire, to achieve, not merely to do a job, became at least a possibility for daughters as well as for sons.”<sup>129</sup> Hitchcock’s reasoning for entering the army supports this notion, and contradicts the idea that women in caregiving professions mythologized a “calling” to work based on a moral duty.<sup>130</sup> Hitchcock, for one, was less attracted by the military’s request for women with tact, cheerfulness, and patience, than she was by the prospect of personal betterment. Her mother had been a Red Cross Nurse, which likely influenced her decision to join army ranks as an occupational therapist:

Long before the United States declared war on Germany, I wanted to go overseas. Probably my motives were mixed. The tremendous odds against the allies appealed to all the chivalry of youth, sense of romance and adventure. The military atmosphere in which I was steeped at that time also undoubtedly influenced me. Then also I very probably entertained a vain desire to prove my courage and achieve heroic deeds. I need not point out that the dreams engendered by my childhood diet of tales of heroism and patriotism never materialized but, whatever the motives, I was determined somehow to get there.<sup>131</sup>

Prior to departing for service as a reconstruction aide in France, Hitchcock, who was born in Virginia, paid a visit to her grandfather. Since she was the “only one in the family who the army wants and will take,” he told her, she “must hold the banner high as the men and women of (her) family had always done.” As Hitchcock’s grandfather bid her farewell, he added: “May God bless you and keep you and help you to fulfill your duty,” then handed her a check. Across the bottom, he had written “For Patriotism.”<sup>132</sup>

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<sup>129</sup> Kessler-Harris, *Out to Work: A History of Wage-Earning Women in the United States*, 226.

<sup>130</sup> Quiroga, *Occupational Therapy: The First 30 Years, 1900 to 1930*, 77-8. Quiroga does note that occupational therapists were representative of the phenomenon of the “new woman,” and sought independence by leaving home. She also argues that occupational therapy (as opposed to nursing) was seen as the province of the elite. Nurses’ training took place in hospitals, she points out, which were seen as “repositories for the working class instead of beacons of science,” whereas occupational therapists were drawn by the profession’s “elite status” and educated in universities. p. 188.

<sup>131</sup> Hitchcock, “The Great Adventure”, II.

<sup>132</sup> *Ibid.*, XI.

Alberta Montgomery's service at Walter Reed illustrates the wartime entrenchment of a burgeoning profession. One of seven children of a central Illinois farmer, Montgomery was a 1915 graduate of Columbia University's Teachers' College.<sup>133</sup> James E. Russell, who so clearly delineated the difference between "full-blooded men" and "weaklings," served as the Dean of the Teachers' College, which was a center of the occupational therapy movement in the years leading up to the World War. By 1918, its students were making "practice-teaching" visits to a nearby hospital, helping to shape one of the first formal occupational therapy training programs.<sup>134</sup> Montgomery, for her part, took a wide range of courses as an undergraduate at J. Millikan University and later at Columbia, including Latin, French, German, algebra, geometry, physics, chemistry, botany, physiology, biology, zoology, agriculture, ancient history, U.S. history, and civics. On applications for teaching jobs, Montgomery noted that drawing and art were her specialty areas.<sup>135</sup> When she was appointed as a reconstruction aide at Walter Reed in August 1918, she left a job in the Art Department of a Decatur, Illinois high school.<sup>136</sup>

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<sup>133</sup> 1900 United States Federal Census, Austin, Macon, Illinois, Roll: T623 323, Enumeration District 44: United States Census Bureau, 1900).

<sup>134</sup> Quiroga, *Occupational Therapy: The First 30 Years, 1900 to 1930*, 115. For a summary of the army's efforts to train recruits, see p. 178-188.

<sup>135</sup> "Boynton-Esterly Teachers' Agency Application", April 8, 1915. Montgomery Collection, Otis Historical Archives 245, Box 9, Folder: Correspondence and Notes, National Museum of Health and Medicine, Washington, D.C.

"The Albert Teachers' Agency Application", April 22, 1915. Montgomery Collection, Otis Historical Archives 245, Box 9, Folder Correspondence and Notes, National Museum of Health and Medicine, Washington, D.C.

<sup>136</sup> Montgomery's decision to accept the job at Walter Reed appears somewhat sudden. A May 10 letter from the Decatur Public Schools requests that she return her contract for the coming school year. By September 5, another letter had arrived from the district superintendent, requesting a meeting to discuss "the vacancy you are leaving in the Art Department of our high school." Arthur Kinkade, "Letter to Alberta Montgomery from Arthur Kinkade, Secretary-Business Manager, Board of Education, Decatur Illinois Public Schools " May 10, 1918. Montgomery Collection, Otis Historical Archives 245, Box 9, Folder: Correspondence and Notes, National Museum of Health and Medicine, Washington, D.C.



While serving at Walter Reed, Alberta Montgomery and Lena Hitchcock joined a long battle waged by women to enhance their citizenship rights and better their professional conditions through military service. They and their counterparts joined the United States military during World War I for the same variety of reasons – from personal to patriotic – as their male counterparts. Mercedes Graf emphasizes this point in regard to women contract surgeons' service during the Great War: "Many enterprising women doctors were guided by their desire to become more active in the war effort as well as to prove themselves as professionals."<sup>137</sup> For women as well as men, the military served as an integral institution of the state, wherein citizenship rights and privileges might be claimed and forwarded.

Thousands of women partook in the Great War effort as part of the U.S. Navy, Marines, and Signal Corps, as well as by serving in social welfare organizations such as the Red Cross, the YMCA, and the Salvation Army. In the latter capacity, they filled a wide variety of roles, including acting as medical professionals at foreign base hospitals and organizing war bond fundraising drives.<sup>138</sup> The most egalitarian of the military branches was the U.S. Navy, which opened its ranks to 11,000 women who served as so-called "Yeomanettes," a handful of whom were African American. Providing much needed clerical assistance in offices both in the country and abroad, these young women – much to the dismay of many contemporary observers – were paid the same wages as their male yeoman counterparts.<sup>139</sup> The Marine Corps also recruited

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J.O. Engleman, "Letter to Alberta Montgomery from J.O. Engleman, Superintendent of Decatur Illinois Public Schools " September 5, 1918. Montgomery Collection, Otis Historical Archives 245, Box 9, Folder: Correspondence and Notes, National Museum of Health and Medicine, Washington, D.C.

<sup>137</sup> Mercedes Graf, "With High Hopes: Women Contract Surgeons in World War I," *Minerva* XX, no. 2 (2002).

<sup>138</sup> On the mobilization of women in World War I, see Jensen, *Mobilizing Minerva: American Women in the First World War*.

<sup>139</sup> Gavin, *American Women in World War I: They Also Served*, 1-19. More than a dozen African American women served as Yeomanettes in a newly created muster roll section under an African American section chief. Kelly Miller,

women for clerical jobs – though it did so almost a year and a half after the Navy, in August 1918, only once it became clear that there was a grave shortage of personnel. Like the Navy, the Marines hoped to reserve males for tasks seen as more physically grueling than office work.<sup>140</sup>

Women who served as nurses throughout the eighteenth and nineteenth centuries helped pave the way for their counterparts to be recruited in the World War I era. Thanks to the establishment of a permanent Nurse Corps in the army in 1901, and in the navy in 1908, military nurses were no longer considered civilian personnel, but instead, appointees of the military branch with which they served.<sup>141</sup> By virtue of that fact, by World War I, women nurses enjoyed some limited rights and privileges.<sup>142</sup> In October 1917, the War Risk Insurance Act extended entitlements directly to female members of the Army and Navy Nurse Corps. Section 300 of the Act stipulated that the policy's compensation rules applied to "any commissioned officer or enlisted man or... any member of the Army Nurse Corps (female) or of the Navy Nurse Corps

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*History of the World War for Human Rights* (Washington, D.C. and Chicago, Illinois: Austin Jenkins Co., 1919), 555-99.

<sup>140</sup> Gavin, *American Women in World War I: They Also Served*, 25-37.

<sup>141</sup> The most comprehensive source on the Army Nurse Corps is Mary T. Sarnecky, *A History of the U.S. Army Nurse Corps*, Studies in Health, Illness, and Caregiving (Philadelphia, Pennsylvania: University of Pennsylvania Press, 1999). On the Navy Nurse Corps, see Vincent Dermott Hickey, "The First Ladies in the Navy: A History of the Navy Nurse Corps, 1908-1939" (Master's Thesis, George Washington University, 1963). Edna M. McCorkle, "Nursing in the Navy," *The American Journal of Nursing* Vol. 41(November 1941).

<sup>142</sup> By World War I, nurses were considered military appointees, not civilians, but they still did not hold military rank. That meant that their "authority to give orders was continually disputed and ignored by the enlisted men who served as orderlies and serious delays in the execution of orders resulted..." Jo-Anne Mecca, "'Neither Fish, Flesh, nor Fowl' The World War I Army Nurse," *Minerva* XIII, no. 2 (1995). According to some scholars, the question of female rank was seen as less pragmatic than ideological: "Opposition to granting military status in any form to nurses remained strong simply and only because they were women." The struggle continued until June 1920, when President Woodrow Wilson signed the Army Reorganization Bill, which granted army nurses "relative rank." As such, they obtained some military and social privileges of regular officers, and the right to wear military insignias. Pension benefits came slightly later, in 1922. Jeanne Holm, *Women in the Military: An Unfinished Revolution* (Novato, CA: Presidio Press, 1982), 9.

(female)...”<sup>143</sup> Later interpretations of the law stipulated that since “medical, surgical, and hospital services are by law furnished ‘in addition to compensation,’” anyone eligible for compensation was, by extension, eligible for medical care.<sup>144</sup> By April 1921, government officials were guaranteeing that more than 34,000 women who served as army and navy nurses, navy Yeomanettes, and in the marines “shall receive the compensation and disability allowances from the government.”<sup>145</sup>

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<sup>143</sup> An Act to Amend an Act Entitled 'an Act to Authorize the Establishment of a Bureau of War Risk Insurance in the Treasury Department,' Approved September Second, Nineteen Hundred and Fourteen, and for Other Purposes, Public Law 90, H.R. 5723, 40 Stat. 398, Sixty-Fifth Congress, First Session, (Washington, D.C.: Government Printing Office, October 6, 1917), 405.

<sup>144</sup> Additional Hospital Facilities for Discharged Soldiers, Sailors, Marines, and Army and Navy Nurses, House Document No. 481, 30.

<sup>145</sup> "Women War Veterans," *The Daily Star* May 20, 1921. In 1921, 236 of the approximately 58,000 veterans treated in hospitals courtesy of the newly created Veterans' Bureau were women. Annual Report of the Director, United States Veterans' Bureau for the Fiscal Year Ended June 30, 1922, (Washington, D.C.: Government Printing Office, 1922), 212. But not all government facilities allowed access to women; for example, veterans of the Nurse Corps were not eligible to be treated in National Soldiers' Homes until 1928. An Act to Amend the Act of June 7, 1924, Prescribing the Persons Entitled to the Benefits of the National Home for Disabled Volunteer Soldiers and the Method of Their Admission Thereto, Public Law 184, H.R. 232, 45 Stat. 366, Seventieth Congress, First Session, (Washington, D.C.: Government Printing Office, March 26, 1928).



*According to the caption for this photo, which appeared in The Outlook, the newspaper of U.S. Base Hospital 116 in France: "German shells and bullets did not spare army nurses. Miss Johnston, wounded while helping other wounded soldiers (for she belonged to the Army herself), returned to America lately on the hospital ship 'Comfort' together with many of her wounded men comrades."'<sup>146</sup>*

Occupational therapists (along with contract nurses and Signal Corps telephone operators) who had been recruited for the war effort as civilians, enjoyed no such political favor.<sup>147</sup> In the 1920s and 1930s, they attempted to obtain higher salaries and military rank, joined in their efforts by two other new and female-dominated groups within the military health care infrastructure: dieticians and physiotherapy aides. Emma E. Vogel, supervisor of physiotherapy aides at Walter Reed, wrote to the Army Surgeon General in 1930 to note that the

<sup>146</sup> ""A Wounded Army Nurse," Photo from *the Outlook*, Newspaper of Base Hospital 116", 1919. Papers of Rustin McIntosh, 1917-1986, Box 1, Folder Base Hospital 116, Miscellaneous, 1919, Columbia University Medical Center Archives, New York, New York.

<sup>147</sup> On groups excluded from the provisions of the War Risk Insurance Act, see *Compilation of War Risk Insurance Letters, Treasury Decisions, and War Department Circulars Relating to War Risk Insurance*, from December 21, 1917 to April 1, 1919, (Washington, D.C.: Government Printing Office, 1919), 11.

military failed to guarantee raises for aides after set periods of time. "If we wish to retain our head aides in the service over a period of several years," she wrote, "it will be necessary to increase the salary." Vogel went so far as recommending that the army decrease the first-year salaries of beginning aides, and use the savings to increase the salaries of head aides, "thus making a substantial inducement to remain in the Service, and to undertake additional responsibilities."<sup>148</sup>

Alberta Montgomery, Vogel's colleague and head occupational therapist at Walter Reed, furthered the point in a subsequent letter to the Army Surgeon General. Montgomery seconded Vogel's request for higher salaries and raises after continued service. She also went a step further, arguing that occupational therapy aides should not serve as civilian personnel, but within a medical auxiliary unit with a "more clearly defined status carrying the privilege of retirement for length of service or for disability."<sup>149</sup>

J.B. Huggins, Colonel in the Army Medical Corps, responded collectively to letters regarding salaries of physiotherapy and occupational therapy aides, as well as another regarding "the status of the dietician in U.S. Army hospitals." Huggins, perhaps, felt his office was under sustained, calculated attack; the three letters to which he referred were sent within weeks of each other. He was, at points, chilly in his reply. To provide salary increases on the scale proposed, Huggins argued, would cost \$30,000 in the first year alone, "which, of course, would be out of the question." After all, appropriations for the medical and hospital department, he reminded the aides' advocates, were "being constantly reduced." Furthermore, Huggins argued, "if it were

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<sup>148</sup> Emma E. Vogel, "Increased Salary for Physiotherapy Aides" April 14, 1930. Montgomery Collection, Otis Historical Archives 245, Box 2, Folder: Occupational Therapy new salary scale, National Museum of Health and Medicine, Washington, D.C.

<sup>149</sup> Alberta Montgomery, "Graduated Salary Scale for Occupational Therapy Aides" February 6, 1931, Ibid. Otis Historical Archives 245, Box 2, Folder: Occupational Therapy -- new salary scale,

possible to adopt such a system, it is not believed that it would be in the best interests of the service to promote these employees automatically according to years of service.” He did agree to decrease the salaries of newly graduated reconstruction aides (from \$1440 to \$1320), and to provide higher pay for head aides. But, such adjustments would cost \$6,440, which the complainants were asked to cover through a general “reduction in force.”<sup>150</sup> The women therapists had achieved something, but, in the larger picture, the arrangement seemed a Faustian bargain, at best.

That is not to say that occupational therapists did not make major gains during and as a result of the Great War. Indeed, the profession was legitimized by the actions of reconstruction aides, who had made a place for themselves in a national program to usher ill and wounded American soldiers swiftly back to physical “usefulness.” Even as army elites and medical personnel debated the utility of occupational therapy, as well as its purposes and strategies, military infrastructure provided a rich forum for professional growth. By 1917, occupational therapists had formed their own national professional organization, the Association for the Promotion of Occupational Therapy, (later re-named the American Occupational Therapy Association), and, soon after, established education and training standards. Regardless of debates that persisted during World War I and in the early 1920s about the usefulness of OT, the army’s investment in it as a viable therapy with medical value and its widespread use in the treatment of soldiers and veterans legitimized it as a new professional field. Meanwhile, repeated attempts by World War I occupational therapists to gain fuller access to benefits finally bore fruit six decades

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<sup>150</sup> J.B. Huggins, "Civilian Personnel" March 24, 1931, Ibid.

after the war; in 1977, they, along with Signal Corps operators, clerks, and hospital dieticians who served between 1917 and 1919 were finally recognized as veterans.<sup>151</sup>

### Conclusion

In the 1920s, the United States government was faced with a vexing problem: What about the soldiers who do not get better? What about long-term ailments like respiratory diseases and mental illness? When, and in what manner, should the enlisted man be, to use the parlance of the time, “disposed of”?<sup>152</sup> As Walter Reed’s beds emptied of American Expeditionary Forces troops, enrollment in all areas of OT activities declined sharply. Between 1922 and 1926, 42 to 57 percent of hospital patients were enrolled in occupational therapy at any given time. By August 1927, only 33 percent of patients were partaking in OT. Two years later, in October of 1929, only 26 percent of hospital patients were doing so.<sup>153</sup>

The focus of the OT program also changed over time. In December 1918, commercial work attracted large numbers of the 1,449 patients participating in occupational therapy work at the hospital, but traditional arts and crafts activities were much less popular: 142 patients partook in courses such as typewriting and bookkeeping, while only seven patients were enrolled in

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<sup>151</sup> Gavin, *American Women in World War I: They Also Served*, 118.

<sup>152</sup> Walter Reed Army General Hospital reports from 1910 through the early 1920s used the term “otherwise disposed of” to refer to patients who left the hospital for reasons other than those typically listed, such as death, discharge for disability, desertion, or transfer to another hospital. See “Walter Reed Army General Hospital Annual Report For...”.

<sup>153</sup> During the same seven-year period, the number of patients in the hospital decreased overall only slightly, from 994 patients at the end of May 1922 to 861 at the end of October 1929), with some minor increases and decreases beyond those levels during some months between those dates. “Monthly Reports of the Occupational Therapy Department, Walter Reed General Hospital/Army Medical Center”, 1922-1929 Otis Historical Archives 245, Montgomery Collection, Box 3, Folder: Monthly Reports of Occupational Therapy -- 1924-25-26, National Museum of Health and Medicine, Washington, D.C.

jewelry, four in engraving, and five in clay modeling.<sup>154</sup> A 1922 report from the Walter Reed occupational therapy department noted, “The men have been encouraged to take educational work rather than some type of craft work which would not prove so beneficial.”<sup>155</sup>

But by April 1922, in spite of administrators’ best efforts to encourage patients to partake in supposedly useful pre-vocational classes, it was clear that a shift was underway – patients were moving away from commercial work and toward arts and crafts: by far, the most popular occupational therapy activity at Walter Reed was “reed, cane and fibre work,” an antiquated means of crafting chairs and other items; following close behind was textile work and woodwork.<sup>156</sup> Over time, the mission of occupational therapy was re-defined from the practical restoration of manhood through the implantation of industrial usefulness to the Progressive Era goals of the profession – quelling hearts and minds of prospective, though damaged, workers. By 1926, when enrollment in crafts had further increased, the annual report of the Army Surgeon General hinted at a population of increasing concern: OT reportedly garnered “excellent results in the treatment of nervous and mental patients.”<sup>157</sup>

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<sup>154</sup> Enrollment was highest in “ward occupations” -- bedside projects, such as knitting -- but this was most likely due to the fact that patients were bedridden and had little choice. 532 patients were enrolled in ward occupations and 142 in commercial work. Baldwin, "Report of the Department of Occupational Therapy, Walter Reed General Hospital, Takoma Park, D.C.".

<sup>155</sup> Annual Report of the Surgeon General to the Secretary of War, 1922: Government Printing Office, Washington, D.C., 1922), 215.

<sup>156</sup> Again, the possibility of enrollment caps cannot be ruled out, though hospital documents contain no evidence that such caps existed. In 1922, 139 patients participated in reed, cane and fibre work. 60 patients were enrolled in commercial courses, such as bookkeeping, shorthand, and typewriting classes. Patients also capitalized on academic opportunities in the hospital, with 52 enrolled in English classes, and 41 in arithmetic. For enrollment figures: "Walter Reed General Hospital Monthly Educational Report for April, 1922", May 8, 1922. Montgomery Collection, Otis Historical Archives 245, Box 3, Folder: Monthly Reports of Occupational Therapy -- 1924-25-26, National Museum of Health and Medicine, Washington, D.C.

<sup>157</sup> Annual Report of the Surgeon General to the Secretary of War, 1926: Government Printing Office, Washington, D.C., 1926), 355.



There are both pragmatic and theoretical explanations for the decreasing popularity and changing nature of occupational therapy services at Walter Reed. In general, army hospital services inevitably balloon during times of war then shrink thereafter. In some respects, the hospital's World War I era program existed and lasted as long as it did because of a dearth of other options; in the months immediately following the war, there was no comprehensively organized veterans' hospital system in the United States and pre-war policies mandated that the Army's Office of the Surgeon General plan for and ensure services for injured and ill soldiers. Occupational therapy, which had gained credence as an effective means of industrial rehabilitation around the turn of the century, seemed to many like a worthwhile addition to the military program. Goals were less clear following the war, as the Federal Board for Vocational Rehabilitation became more involved in soldiers' care, and army hospitals like Walter Reed played host not only to enlisted personnel, but also to chronically ill veterans whose care was paid for by the Bureau of War Risk Insurance. During this later period, a new veterans' medical system was taking root, and administrators and government officials faced basic questions about how to coordinate care, where new hospitals should be located, who should be admitted to them, and how much funding they should receive. At Walter Reed, as occupational therapists and rehabilitation experts focused on ensuring that soldiers would re-enter society as productive citizens, if not workers, army and government officials focused on the broader mission of boosting the morale of wounded and ill troops, even as they began to trim the wartime rehabilitation program. We will see that they faced staunch resistance from soldiers themselves, who felt the government owed them more than it was offering.

## CHAPTER THREE

### **Soldier-patients become civilian-citizens: Shifting presentations and perceptions of a military hospital (1918-1920)**

Paul A. Bazaar recalled spending his early days at Walter Reed Hospital in “sober reflection.” The long, bed-lined wards and pastoral grounds were a world away from the front, where Bazaar had lost both of his hands when a grenade detonated prematurely. At Walter Reed, he said, “I painfully nursed the birth of a new hope, I made that little sphere the starting point of a new and brighter life...” Bazaar was discharged in February 1919, after being fitted with metal prostheses. By January 1921, he had graduated from business school, and was making a living in Rochester, New York, assisting people with their income-tax returns. “I am doing quite well,” he reported in a letter. “I find the going exceedingly rocky at times, and the obstacles many, but my philosophy, a light heart and a smile, helps to surmount most difficulties.”<sup>1</sup>

Of the approximately 230,000 American Expeditionary Forces troops wounded abroad, more than 50,000, like Bazaar, received treatment in U.S. military hospitals.<sup>2</sup> The army sent the most complex cases to one of its general hospitals, which offered patients relatively advanced technologies and procedures, as well as some of the most extensive available rehabilitation options.<sup>3</sup> There, recovering soldiers faced the reality of their physical conditions, and the notion that they were no longer combat-ready soldiers. At domestic military hospitals – for many ill and injured troops, one of the first stops on home ground – the government and army attempted to ensure that service members smoothly re-acclimated to a particular type of civilian life. Not all

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<sup>1</sup> “He ‘Comes Back’ by Aiding Folks with Income Tax,” *The Come-Back* January 22, 1921, 6.

<sup>2</sup> “Medical Branch Handles Task in Capable Manner,” *The Come-Back* Vol. 2, No. 52(December 4, 1920). The number is also reported in Albert G. Love, “A Brief Summary of the Vital Statistics of the U.S. Army During the World War,” *The Military Surgeon* Vol. LI, Number 2(August 1922).

<sup>3</sup> See Chapter Two for more background on general hospitals.

discharged veterans were, in the eyes of the army and government, as successful as Bazaar; he had used his hospital time wisely, coming to terms with his injury instead of resenting it. He had taken advantage of the medical care offered to him, unlike many others who signed off their rights to government-sponsored health services in order to obtain a hasty discharge. Bazaar had even gone on to obtain professional training, and become a working member of society. His was a model case.

One thing about Bazaar's experience, however, was typical: Walter Reed served as "the starting point of a new life" for many of its thousands of patients during and immediately after World War I. The hospital was a testing ground for the government's rehabilitation program and its ideology of cure.

The content of the Walter Reed's newspaper, *The Come-Back*, during and immediately following the war demonstrates the high hopes the military and government had for healing wounded soldiers and returning them to society as so-called able-bodied citizens. *The Come-Back* reflected the government's desire to represent military hospitals as camp-like sanctuaries of learning, healing and growth. In this way, according to the newspaper, the institution harkened back to the nineteenth-century ideal for hospitals. It was more than a place to receive medical care; it constituted a tight-knit community rife with opportunities for educational and professional training that could equip patients with the tools necessary to enter the outside world. But the newspaper also hinted at the fact that military hospitals like Walter Reed were a harbinger of the dawning age of institutionalized, medicalized comprehensive care.<sup>4</sup> It focused

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<sup>4</sup> See Chapter One for a summary of historians' interpretations of the transition in hospital care – from moralistic to medicalized – at the turn of the century. Helpful sources include: David Rosner, *A Once Charitable Enterprise* (Cambridge: Cambridge University Press, 1982). Morris J. Vogel, *The Invention of the Modern Hospital: Boston, 1870-1930* (Chicago: University of Chicago Press, 1980). Rosenberg, *The Care of Strangers: The Rise of America's Hospital System*. Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (New York: Basic Books, 1989).

on the activities of a community of devoted caregivers, trumpeted the considerable accomplishments of military medicine and newly emergent specialty care, and promoted a proud rendition of the history of one of the Army Medical Department's most venerated institutions.

While *The Come-Back* put forth a largely positive image of Walter Reed, patients and their relatives filed complaints alleging that care and conditions at the facility were unsatisfactory. Their claims illuminate some emerging issues of tension regarding standards for government-provided hospital services: what did the army owe injured and ill soldiers? When should they be discharged from the military and what part should the government play in ensuring their wellbeing as civilians?

As emerging veterans' advocacy groups such as The American Legion began to address these complex questions, and as the halls of Congress reverberated with calls for "adjusted compensation," vocational training, and comprehensive medical care for former A.E.F. troops, the pages of *The Come-Back* reflected, in real time, how the army grappled with difficult realizations regarding soldiers' health. As such, the newspaper's consistently rosy coverage gradually gave way to tacit acknowledgements of shortfalls in the system. By 1920, it represented illness and injury not just as vague hurdles to overcome before one could hastily return to a job and family, but, occasionally, as arduously painful life-long challenges. The newspaper's constant coverage of pending legislation pertaining to medical care and benefits served as an acknowledgement that access to hospitals and disability services was an issue of central political importance, and a societal conundrum of great proportions.

### Origins of The Come-Back

In the fall of 1918, the Army Surgeon General established the Section of General Publicity to oversee the content of more than 40 newspapers published in hospitals abroad and in the U.S. with the hope that they could serve as potential morale-boosters. The new office would establish, supervise, and maintain publications “of interest and benefit to the patients, personnel and the community in general.” The Section of General Publicity kept “a watchful eye” on the publications it oversaw, even distributing a weekly newsletter to serve as a guide for potential topics worthy of coverage. But the production of newspapers like *The Come-Back* was reliant on the patients it aimed to reach: “Soldier talent secures the materials, soldier talent edits, and in many instances, soldier talent actually produces the paper on the press.”<sup>5</sup> Still, rank-and-file personnel had limited autonomy. It is difficult to determine who actually penned articles that appeared in Walter Reed’s newspaper, since the large majority of the pieces contained no bylines, but it was primarily officers’ names that were listed in the editorial staff on each edition’s masthead. Majors, not Privates, it seems, ultimately determined what would appear in print.

Rehabilitation experts had long boasted of the potential benefits of such publications for soldier-patients. The army received reports that hospital newspapers and pamphlets helped convalescing European troops pass time more pleasantly and constructively. The German Lubbecker Lazarett-Zeitung (Lubeck Hospital Journal), for example, was “meant to influence the war cripple while he is in hospital and prepare his mind for the future,” Ruth Underhill, a researcher for the Red Cross, reported in September 1918, around the time the Section of General Publicity was established by the U.S. Army Surgeon General. “Among short bits of

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<sup>5</sup> "The Hospital Publication in Reconstruction Work of the Army". Otis Historical Archive 245, Montgomery Collection, 1915-1943, Box 1, Folder 9, National Museum of Health and Medicine, Washington, DC.

news about trades and pensions, (the Lubbecker Lazarett-Zeitung) has inspiring verses and talks on the joy of suffering for the Fatherland, and each month an article on the German nature, featuring such qualities as industry, courage, patience, and patriotism.”<sup>6</sup> *The Come-Back*, one of more than 50 newspapers published in domestic military hospitals, assumed a similar structure, though the propagandistic tone alluded to by Underhill was, on rare occasions, subsumed by editorial content that was somewhat more reflective of the realities of soldiers’ and veterans’ lives, and their political desires.<sup>7</sup>

*The Come-Back* was not the only hospital newspaper published in the aftermath of World War I, but because of its relatively extended run time and the fact that it was the paper of record for Walter Reed Army General Hospital, the site of care for some of the country’s most severely injured soldiers, it is an especially rich source. Published weekly from December 1918 through March 1921, it serves as a gauge of how priorities and concerns of the Army Surgeon General’s Office and other government entities changed and evolved during a turbulent time.

Scholars have recognized the utility of hospital newspapers as historical sources. Jeffrey Reznick argues that magazines of British military hospitals were intended to convey a positive image of the institutions as “relaxed and harmonious,” but that soldiers resisted what they

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<sup>6</sup> Ruth Underhill, "Provision for War Cripples in Germany," *American Journal of Care for Cripples* Vol. VII, no. 1 (September 1918): 31.

<sup>7</sup> The statistic regarding the publication of 50 hospital newspapers is from Frank W. Weed, *Medical Department of the United States Army in the World War; Volume 5: Military Hospitals in the United States*, ed. M.W. Ireland (Washington, D.C.: Government Printing Office, 1923), 169. Multiple titles are available at the United States Army Heritage and Education Center in Carlisle, PA, including: *About Face*, published at the U.S. Army Base Hospital, Fort Sam Houston, Texas, Feb-Jul 1919; *As You Were* published at General Hospital No. 24, Pittsburgh, PA, Feb-June 1919; *The Cure* published at Base Hospital, Camp Upton, NY, Nov. 30, 1918, Dec 21, 1918, Dec. 29 1918; *Over the Top*, published at Camp Zachary Taylor, Kentucky, June 25 1919; *Ontario Post* published at Fort Ontario, Oswego, NY, Sep-Nov 1917; *Here and There*, published at Base Hospital at Fort Meade, MD, April – June 1919; *The Mess Kit*, published at Camp Merritt, NJ, March, April, July 1919; *The Caduceus* published at Base Hospital at Camp Greene, NC, Aug 17 1918; *The Dooins*, published at U.S. Reserve Base Hospital No. 2, Sep. 1917-Jan. 1918; *The “9” Times*, published at U.S. Base Hospital No. 9, American Expeditionary Forces, France, Feb.-June 1918; *Tehshun, 21!* Published at General Hospital 21, Denver, Co., May 22, 1919; *The Yankee Flare*, published at Base Hospital, Camp Devens, MA, April 1919.

deemed the “repressive nature of the hospital regime.”<sup>8</sup> Beth Linker writes about *The Come-Back* and a later magazine, *Carry On*, which had a related mission, as well as patient complaints regarding Walter Reed. Linker argues that the publications had three primary aims: convincing soldiers that rehabilitation was “the best form of compensation for their injuries,” one for which they should be grateful. Second, she says, the newspapers aimed to demonstrate that hospital-based reconstruction was a better alternative than returning home and seeking care from local communities. Finally, Linker argues, the publications aimed to be cheerful and supportive of the War Risk Insurance Act and the war itself. While the newspaper showcases the ideological portrayal of the rehabilitation program, Linker says, patients’ testimonies provide evidence of “lived experience,” and demonstrate that soldiers’ expectations went beyond the provisions of the WRIA.<sup>9</sup>

I build upon and diverge from these arguments about the relevance of hospital newspapers and patients’ testimonies. Generally, I am concerned not only with the propagandistic tone of *The Come-Back*, but also with how the messages of the army-monitored newspaper came to reflect the undeniable realities of what was, for soldier-patients, the army and the government, a time of great adjustment. While Reznick and Linker juxtapose newspapers and soldiers’ complaints with their larger points about (respectively) the social experience of British army medical care and changing notions of disability, I examine both in the context of the eventual advent of a veterans’ hospital system within a developing American veterans’ welfare state. I build upon Linker’s findings regarding how *The Come-Back* attempted to sell the mission

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<sup>8</sup> Jeffrey S. Reznick, *Healing the Nation: Soldiers and the Culture of Caregiving in Britain During the Great War* (New York: Palgrave, 2004).

<sup>9</sup> Beth Linker, *War’s Waste: Rehabilitation in World War I America* (Chicago, Illinois: University of Chicago Press, 2011), See Chapter Six.

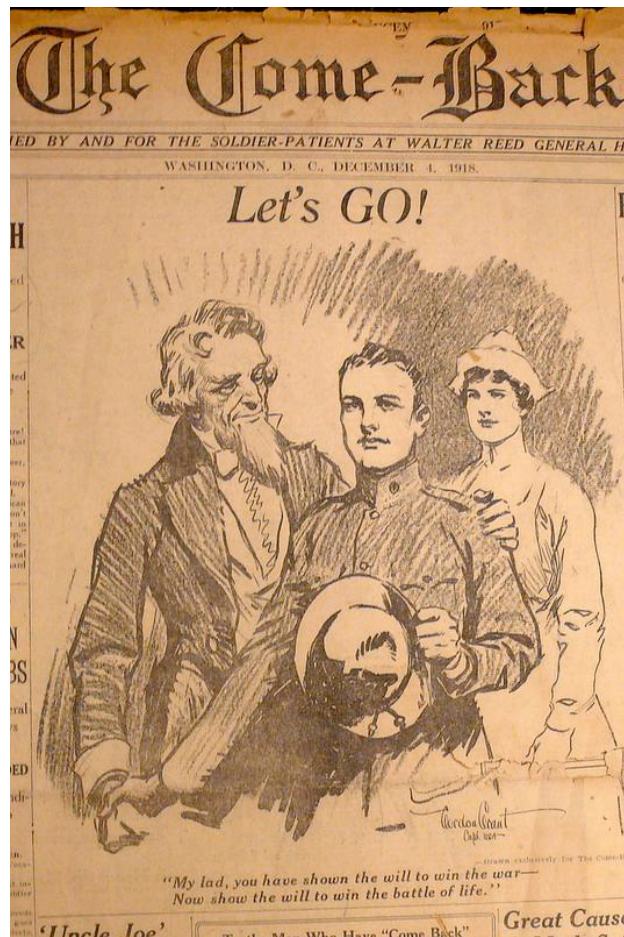
of “reconstruction” to soldiers themselves, and how the newspaper helped bolster the idealization of medical care as one form of payback for wartime sacrifices. But I also view the newspaper as more than propaganda; by late 1919, it served as a gauge of government-level sentiment about the changing nature – and many challenges – of the project of soldier rehabilitation. Although it trumpeted the promise of the WRIA, its tone regarding later legislative and systemic shortfalls was indicative of a larger realization that the contemporary system was becoming truly dysfunctional for all concerned – medical professionals, bureaucrats, and patients alike. The newspaper’s changing tone reflected not only political transitions and difficulties, but also the undeniable reality of the hospital experiences of soldiers themselves.

“Every day brings happy moments”: the hospital, according to the Come-Back

As the public organ of one of the premier military hospitals in the United States, a primary goal of *The Come-Back* was to represent Walter Reed Hospital in the best possible light. Articles in the newspaper characterized the institution as a place that offered much more than medical care; it constituted a tight-knit community where patients could capitalize on opportunities for educational and professional training that would equip them with the tools necessary to enter the outside world. The military hospital was portrayed as a somewhat idyllic place where “buddies” could attend concerts, sporting events, sightseeing trips, and holiday parties sponsored by generous Washingtonians and beneficent welfare organizations. Furthermore, the newspaper reminded its readers that Walter Reed was different than other military hospitals. It was the site of state-of-the-art care for the most complex medical cases. There, patients were treated by the most committed professionals – people not only devoted to soldiers’ individual care, but also to the tenets of scientific research.



*The Come-Back* announced itself triumphantly in its inaugural issue of December 4, 1918. A drawing at the center of the paper's first broadsheet page featured a young soldier looking ahead, a female nurse standing behind him, and Uncle Sam at his right, arms around the fighter's shoulder. "My lad, you have shown the will to win the war – now show the will to win the battle of life," read the caption.



The Come-Back December 4, 1918.<sup>10</sup>

According to the newspaper, the assistance of caregivers and the grateful government should be thought of as supplementary to individual motivation and self-worth. An accompanying article

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<sup>10</sup> "Let's Go!," *The Come-Back* December 4, 1918.

explained that *The Come-Back* would be “full of cheer,” and contained a message for the wounded returning from France: “If any of them have a notion that Walter Reed or any other hospital under the Surgeon General’s jurisdiction is a place of gloom, *The Come-Back* will knock it out in sixteen-inch-shell fashion.”<sup>11</sup>

Walter Reed was showcased as a joyful place, where patients celebrated holidays and watched concerts and sports matches. A “great yuletide” was arranged for Christmas of 1918, with “smokes and eats for all,” and there was extensive coverage of the many sports teams formed by the Red Cross Recreation Division.<sup>12</sup> In January 1919, boxing matches were held between various members of the hospital staff of the Quartermaster Corps and the Knights of Columbus. The featured bout was between Sergeant Joe Chip of the Reconstruction Division, (reputed to be the “fastest middle-weight in the Army”) and Private Schaeffer of the Quartermaster Corps. “The whole evening’s entertainment was of a very meritorious character,” *The Come-Back* reported, “and it will be noted that every one of the performers are men attached to this post, proving that Walter Reed Hospital can live up to its high reputation in this as well as in many other lines.”<sup>13</sup> Walter Reed was home to an array of social options for both patients and staff. The YMCA, Red Cross, Knights of Columbus, and Jewish Welfare Board each had facilities by early 1919 on or near the hospital’s campus, and sponsored a plethora of activities, including movie screenings, dances, and sightseeing trips around Washington, D.C., many of which were enthusiastically covered by *The Come-Back*.

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<sup>11</sup> “First Paper in History Longing for a Quick Death,” *The Come-Back* December 4, 1918.

<sup>12</sup> “Great Yuletide Is Planned at Walter Reed,” *The Come-Back* December 18, 1918. “Biggest Army Christmas Is Held at Walter Reed,” *The Come-Back* December 31, 1918.

<sup>13</sup> “First Boxing Match on Post,” *The Come-Back* January 29, 1919.

A poem published in the March 12, 1919 issue of the paper noted some of the common challenges faced by patients – replaying memories of battles, for example – and the tremendous comfort, cheer, and community found in the services offered by the hospital and its associated organizations:

Many things we will remember  
when discharged and we are freed.  
And our hearts will grow more tender.  
For the years soon pass away.  
And we'll picture scenes and faces.  
Then the memories of today.  
There's the pine trees through the window  
Showing green against the snow.  
And the fireplace in the evening.  
With its coals a rosy glow.  
Where we fight again the battles  
with the boys from o'er the sea.  
And we straighten out the details.  
For they're now but history.  
There's a feeling in our friendship  
For these comrades that will last.  
And we gain a certain pleasure  
In grim pictures of the past.  
Every day brings happy moments.  
For the Red Cross knows our need.  
Many friends in loving service  
Join the work at Walter Reed...  
There is work of reconstruction  
For the men who sadly lack.  
And a paper in the interest  
of the men who will 'Come Back.'<sup>14</sup>

The hospital, like its nineteenth century forebears, was represented as a place where patients could find joy and camaraderie in a communal, home-like atmosphere, but also as a place where they could capitalize on a rich array of opportunities for training and education. Victor Kauffman, a reporter for *The Washington Star* and frequent advocate for the work of

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<sup>14</sup> Corp. Newell B. Davis; Sergt. W.J. Ellison, "Remembrances," Ibid. March 12, 1919.

Walter Reed Hospital, juxtaposed two of the primary missions of the *The Come-Back* and Walter Reed itself: to keep up the morale of “the boys” and create a sense of community, while simultaneously pushing soldier-patients to use their recovery time wisely in order to prepare themselves for civilian existence. “Occasionally one hears the remark made by thoughtless people that too much is being done for the entertainment of the boys at Walter Reed Hospital,” Kauffman wrote. “Their idea is that on leaving the hospital after their discharge these young men will be in an entirely different environment and must look out for themselves.” But, he argued, “all the boys at Walter Reed Hospital have given up months or years of the best part of their lives for their country and their friends, and all of them have made bitter sacrifices. It is my honest belief that they are entitled to a few hours of playtime before settling down to the stern realities of later life.” Kaufman noted, however, that there should be limits to carefree indulgences at the hospital. “All opportunities for enjoyment are liable to be abused,” he said, “and I would urge every boy to take advantage of every opportunity in the matter of education or vocational training before he goes in for any light form of personal amusement or recreation.” Kaufman reminded readers that, “the hospital offers wonderful chances to learn useful trades that will fit the young soldiers to take a very active and responsible part in the big battle of life ahead, and any young man who fails to take advantage of every such chance is his own worst enemy.”<sup>15</sup>

To these ends, *The Come-Back* kept soldier-patients abreast of opportunities to better their physical condition by participating in occupational therapy crafts classes, and their mental, and economic conditions through academic and professional training courses. In March 1919, under the headline “Soldier-patients at Walter Reed Make Progress in Classes,” *The Come-Back* published a list of 27 courses being offered at the hospital, from shorthand and rug-weaving to

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<sup>15</sup> Victor Kauffman, “Happy New Year,” *Ibid.* December 31, 1919.

type-writing, and elementary and general academics. The newspaper reported that 1,072 students were enrolled in classes in March 1919: "Soldiers are alive to the work... 'Prepare now, in the hospital while recovering from one scrap, for the big fight that is to come in civilian life' are the words one soldier used to describe the situation."<sup>16</sup> Soldier-patients read in *The Come-Back* that they could take classes in motion picture operating, electricity, stenography, linotype, and to train for civil service exams.<sup>17</sup> "In auto repair shops," as was the case in many other trades, the newspaper reported, "men who have lost one leg can manipulate the machinery and handle the tools for repairing to the same degrees of efficiency as any man."<sup>18</sup>

Alongside informational pieces about educational opportunities, *The Come-Back* reminded patients that a perfect physique was not essential in order to live a fruitful economic life. A February 1920 editorial was addressed to those who might be skeptical of such an idea. Some, "who should be deeply interested in examples... of wounded men who, while convalescing, have laid plans and foundations for careers, far different from those they pursued in ante-bellum days, which have proven to be a marked successes... merely mutter, 'the lucky bird.'" But, for people like Paul A. Bazaar and other "Johns" who found professional success after being wounded and rehabilitated, it had nothing to do with luck, according to *The Come-Back*. "In reality it is highly probable that, while on a hospital bed, John realized his disability

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<sup>16</sup> "Soldier-Patients at Walter Reed Make Progress in Classes," *The Come-Back* March 12, 1919.

<sup>17</sup> "Who Wants to Learn Motion Picture Operating?," *The Come-Back* December 18, 1918. "Fond of Electricity? Here's a Free School," *The Come-Back* February 5, 1919. "Stenography to Be Taught Here," *The Come-Back* February 5, 1919. "Linotype Class Starts at Reed," *The Come-Back* February 11, 1920. "Y to Train Patients for Government Jobs," *The Come-Back* February 5, 1919.

<sup>18</sup> "One-Armed Boys Hammer Fords," *The Come-Back* February 12, 1919.

would prevent a return to his former employment, made good use of spare moments and minimized the effects of his misfortunes...”<sup>19</sup>

*The Come-Back* offered somewhat conflicting messages regarding soldiers’ opportunities upon discharge. On the one hand, readers were encouraged to visit the library and peruse books about new professions such as advertising, which were typically thought of as less physically demanding modes of employment.<sup>20</sup> But a seemingly contradictory point was communicated in a few articles urging men to return to their previous jobs, regardless of whether they desired a new one. Ex-soldiers should wait for the economy to improve, these articles argued, before making a big move to a large city, or attempting to undertake new employment. According to one *Come-Back* article, “the soldier feels... that he is entitled to a job when he gets out, and sometimes a better job than the one he occupied when he went... He is unqualifiedly right... we want to encourage just this thing.” The newspaper pointed out, however, that while personal initiative was noble, it could bring about only limited results. “The trouble at this time is that just when the majority of our fighting men are being discharged, the industrial situation is in a delicate, disturbed condition... there are not one-half as many jobs available for the discharged soldier and the quest for this better job is liable to meet with unhappy results.” Given this reality, soldiers were advised that, “the best thing for the soldier to do at present, considering the delicately balanced industrial situation... is to return to his former job, if he has one.”<sup>21</sup>

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<sup>19</sup> “Wound Stripes and Opportunities,” *The Come-Back* February 4, 1920.

<sup>20</sup> “Get a Good Start by Visiting the Library,” *The Come-Back* January 15, 1919.

<sup>21</sup> See, for example, “Best Bargain yet, Is Lad from Front,” *The Come-Back* March 19, 1919. Scott Gelber also writes about vocational training programs limiting men from reaching too high. Scott Gelber, “A ‘Hard-Boiled Order’: The Reeduction of Disabled World War I Veterans in New York City,” *Journal of Social History* 39, no. 1 (2005).

In spite of acknowledgements of soldier-patients' limited future employment prospects, *The Come-Back* published testimonials from patients, and stories of successes following training – in large part to convey the importance of pursuing educational opportunities while at the hospital. “When I came to this hospital, I was full of aches and pains and my mind was constantly centered on my future,” wrote Private Frank A. Sobel in a Letter to the Editor on December 31 1919. When a nurse convinced him to enroll in an arithmetic class, he reported, “I at once forgot my aches and pains.” He urged fellow patients not to “push this wonderful opportunity aside.”<sup>22</sup> Another letter to the editor on February 11, 1920 concurred. Lieutenant Newgirk told readers that after he had gotten “some relief from suffering,” he attended classes at Walter Reed, an experience he found to be of “great benefit.” “Often when not feeling able to come I have urged myself and in the doing have found that it helped overcome the pain.”<sup>23</sup>

Why did the army have such a vested interest in the civilian futures of its enlistees? What, after all, could these disabled soldiers offer the military? The training opportunities offered at Walter Reed, in fact, went above and beyond the mission set out for military hospitals by regulations passed prior to and during the war. At first, army officials hoped that men who were missing legs and arms could fill administrative positions in the service if they were properly trained. But by mid- to late 1919, when the war was over and it was clear that there were more disabled men than there were suitable military jobs, injured and ill soldiers became part of a broad attempt at an army institutional renaissance, which took as its primary goal the consideration of the “whole man.” The army was not merely a benevolent institution for men

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<sup>22</sup> Frank A. Sobel, “Letters to the Editor,” *The Come-Back* December 31, 1919.

<sup>23</sup> Lieutenant Newgirk, *Ibid.* February 11, 1920.

who would never return to duty. It was using its interaction with them to create for itself an image as a sophisticated fighting force that not only used men as fodder for wars, but also trained them to be better auto mechanics, pilots, doctors, and the like.<sup>24</sup>

As army brass fought to push through the National Defense Act of 1920, they simultaneously undertook a campaign to re-create the military in the eyes of the public and veterans.<sup>25</sup> Rehabilitating disabled veterans corresponded with the image the army was putting forth of itself as an institutional force that intended to do more than fight, one that held value and rich opportunities for individual citizen-soldiers. To these ends, *The Come-Back* sponsored an essay contest in early 1920 that it promoted week after week, which eventually ended with a celebration held in Washington, D.C. In an effort to help grade school students fulfill the assigned task of writing about the benefits of army service, *The Come-Back* published articles focusing on the topic. Contestants were encouraged to use the articles as guides for their submissions. “There has seldom been a time in the history of the military when an enlisted man of ambition and determination could not improve himself tremendously along educational and vocational lines,” *The Come-Back* declared. “The encouragement of such improvement... was subsidiary to the main object of the small pre-war army,” the newspaper conceded. Before the current conflict, military leaders were focused first and foremost on “the development of the hard-fighting, dependable force capable of expansion, and which was to be the foundation and

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<sup>24</sup> Jennifer Keene argues that the army attempted to make conscript soldiers friendly to its overall mission and goals, seeing them as future voters and potential supporters of pro-military policies. Jennifer D. Keene, *Doughboys, the Great War, and the Remaking of America* (Baltimore: The Johns Hopkins University Press, 2001), See especially Ch. 6.

<sup>25</sup> The Act eventually passed on June 4, 1920 and stipulated that citizen-soldiers would constitute the principal national military force. They would be “prepared for war” through both the National Guard and an Organized Reserve. Military officials failed to convince Congress to include in the Act a long-desired measure for universal military training. Russell Frank Weigley, *History of the United States Army* (Bloomington: Indiana University Press, 1984), 399.



nucleus of a powerful army. In pre-war days," *The Come-Back* noted, "vocational and educational improvement did not constitute the goal which much of the energy of the military establishment was directed." But World War I brought about a tide change, according to the newspaper. "With the lessons of the great conflict being studied diligently, the new army has committed itself to a program of education and instruction which assures every young man a fair start in life."<sup>26</sup>

Going beyond a mere focus on fighting tactics, the army would offer instruction in various trades, from medicine to construction. An article explaining why Walter Reed and other army installations were seeing a proliferation of athletic and recreational facilities explained the tenets of the "new army" similarly. "The policy... was based upon the belief that the responsibility of the War Department for the care and comfort of the soldier does not end with his working day... unlike civilian organizations the War Department feels itself charged with the entire 24 hours of the soldier's day. It clothes and feeds him, it educates him..."<sup>27</sup> Treating and training disabled soldiers was part of a broader vision of a vastly expanded military mission, not to mention good public relations. In order to get "the mothers of America" to "send us the lads from the plains," army brass believed they had to prove they would do right by soldiers, and "build men."<sup>28</sup>

Soldier-patients who capitalized on training opportunities and became productive citizens were not only sources of pride for a military with an expanding vision, *The Come-Back* reminded

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<sup>26</sup> "Forceful Facts About the Army," *The Come-Back* February 18, 1920.

<sup>27</sup> "Education and Recreation in the Army," *The Come-Back* June 26, 1920.

<sup>28</sup> The poem, "To the Mothers of America" by Sgt. Francis P.M. McGinnis, read: "Bring on your boys from the cities, send us the lads from the plains; be they sickly and pale, immature thin and frail, and only a semblance of brains. Let them come from an oversea nation, Swede, Danish or Russian or Dutch, it matters not, a cosmopolite lot – we'll take 'em, and train 'em... have you heard of our army's slogan? We shout it, 'the army builds men!'" "To the Mothers of America," *The Come-Back* April 13, 1920.

readers, but were also part of a grand success story of military medicine, a centerpiece of which was the institution of Walter Reed itself. The newspaper regularly noted that the health care administered at Walter Reed served as a model for other facilities – civilian and military – and that the institution was at the pinnacle of the venerable Army Medical Department. Walter Reed patients were often reminded that they had access to a broad spectrum of professional specialists such as orthopedists, plastic surgeons, and occupational and physical therapists. Although *The Come-Back* contained little coverage of medical care and doctors – technicalities of military medicine and health treatment, it seemed, were best left to journals like *Military Surgeon* – in early January 1921, the newspaper featured a story about a clinic held at the hospital the previous week. Calling it the “largest medical clinic in the history of Washington,” *The Come-Back* reported that more than 150 doctors and students from Johns Hopkins University, George Washington University, and the Army Medical School had observed a presentation by Walter Reed doctors of 50 patient cases with conditions including bone defects, mustard gas burns, amputations, and gunshot wounds. Although patients’ names were kept confidential, the newspaper did report that, “from the point of view of the suffering soldiers undergoing treatment, the interest manifested in them by the clinic was most helpful. It has stimulated the morale of the sick.”<sup>29</sup> Following a tour of the wards of Walter Reed, Brigadier General John M.T. Finney of Johns Hopkins, who was Chief of Medical Services of the American Expeditionary Forces, noted how impressed he was with what he saw. The ongoing work at Walter Reed, he contended, could be helpful in the instruction of doctors and nurses working in industry.

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<sup>29</sup> There are a variety of sources on the rise of patients’ rights and informed consent laws. Susan Lederer argues that the roots of those laws can be found in the years between 1890 and the passage of the Nuremburg Code in 1946. By World War II, Lederer notes, doctors had grown increasingly sensitive to the ethical questions behind using human subjects, but it was standard practice to use hospital patients in order to test the effectiveness of a given treatment, as long as that treatment was presumed to be useful. Susan E. Lederer, *Subjected to Science: Human Experimentation in America before the Second World War* (Baltimore, Maryland: Johns Hopkins University Press, 1995).

Finney argued that the hospital deserved recognition not only for its exemplary care, but even more so because it was dealing with patients who were “the left-overs from the hospitals in Europe and on this side... they are the most chronic and the most difficult to deal with... these are the severest cases of the war... men whose health has long been undermined, whose morale is affected.” The Johns Hopkins doctor called Walter Reed “a wonderful plant,” arguing that there was “nothing like [it] anywhere in the country.” It can’t be excelled,” he said. “You could not go into any civil hospital in the US and see better work and better results than we saw at the clinic today.” Finney pointed out that Walter Reed doctors had devised innovative ways to deal with empyema, a relatively common condition among soldiers of World War I, characterized by a gathering of pus between the lungs and the wall of the chest.<sup>30</sup> They had also revolutionized the art of bone grafting, which allowed a portion of one bone to be used to replace another. “The men shown at today’s clinic, had they been wounded in previous wars, would simply have been abandoned without hope, to become, many of them, public charges,” Finney said. “Now, however a large percentage, indeed, the majority... are being restored to self-respect and self-support.”<sup>31</sup>

The clinic, intended to highlight the valor and uniqueness of the medical work being undertaken at the hospital, helped justify the call from army higher-ups and hospital officials for the expansion of Walter Reed Army General Hospital into a more expansive Army Medical Center, complete with a museum, Surgeon General’s Library, and medical school on premises. The vision of an all-encompassing medical center was consistently trumpeted in the newspaper.

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<sup>30</sup> Treatment standards for empyema adopted by a “Empyema Commission” in 1918, according to one scholar, “form the basis for the treatment of empyema today.” Richard W. Light, *Pleural Diseases, Fifth Edition* (Philadelphia, Pennsylvania: Lippincott, Williams, & Wilkins, 2007), 180.

<sup>31</sup> “Surgical Feats Seen in Clinic at Walter Reed,” *The Come-Back* January 15, 1921.

In November 1918, Army Surgeon General Merritte W. Ireland laid a plan for a larger Walter Reed before the Secretary of War. “For a considerable time” after the war, the Surgeon General pointed out, “many sick and wounded will require treatment, and it is believed that the military population entitled to treatment in military hospitals will be greater after the war than it was before.” The permanent bed capacity at Walter Reed at the time, Ireland said, was only about 2,500. The acquisition of more land would mean that the Secretary of War could “confine all of the Army medical activities in or near Washington on this ground.” It would also provide more space for outdoor recreation, a facility to treat civilian employees of the War Department, and “experts (to be) concentrated at this place to whom all difficult cases in the Service can be referred.”<sup>32</sup> Although the Secretary of War initially rejected the request for more land, he came around to the idea after meeting with Surgeon General Ireland. According to one representative of the Army Chief of Staff, since the land surrounding the hospital would likely “steadily increase in value” the army should “take advantage of the options” which would permit it to “obtain possession of the land, without which there can be no centralization of the Medical and Surgical activities in the District of Columbia so essential to the best interests of the Medical Department.” The Secretary of War thus authorized an expenditure of \$350,000 for the expansion of Walter Reed.<sup>33</sup> But in moving forward with plans, the War Department faced resistance from landowners: “the price demanded” for plots surrounding Walter Reed Hospital,”

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<sup>32</sup> "Memorandum from the Surgeon General, U.S. Army, to the Chief of Staff, Purchase, Storage and Traffic Division (Leasing Branch) Re. Purchase of Additional Land for Walter Reed General Hospital", November 13, 1918. Records of the Adjutant General's Office, Central Decimal Files, 1917-1925, Hospitals St. Elizabeths Hospital to Walter Reed Hospital, Record Group 407, Box No. 1428, Folder 004.61 Walter Reed to 601.1 W.R., National Archives and Records Administration, College Park, Maryland.

<sup>33</sup> "Memorandum for the Assistant Secretary of War: Subject: Additional Land, Walter Reed Hospital, Tacoma, Washington, D.C.", November 29, 1918. Records of the Adjutant General's Office, Central Decimal Files, 1917-1925, Hospitals St. Elizabeths Hospital to Walter Reed Hospital, Record Group 407, Box No. 1428, Folder 004.61 Walter Reed to 601.1 W.R., National Archives and Records Administration, College Park, Maryland.

according to a June 1920 memo from Secretary of War Baker, “is in excess of a fair and reasonable value of the land.”<sup>34</sup>

In spite of such setbacks, by the early 1920s, plans were moving forward on a vast expansion of Walter Reed. A congressionally-approved purchase of land was, Surgeon General Ireland reported in August 1920, the first step in an institutional expansion estimated to cost \$12 million. “This hospital, of course, will never fulfill its mission until it is completed in every respect,” Ireland lamented in *The Come-Back*. “The temporary buildings, constructed in great haste during the war emergency, have served for the care of the soldiers from the world war, but it is necessary to have many additional buildings to complete our plant.”<sup>35</sup> The post World War I period, then, was not only a time of transition and adaptation for disabled soldiers and veterans, but also for the institution of Walter Reed itself. There, Great War era reforms helped push forward plans for a long-sought premier army medical center.

Pre-war policies intended to ensure that ex-soldiers did not become pensioners, then, helped bring about a vast, long-term expansion of notions of what a military hospital should and could do. On September 1, 1923, Walter Reed went from being merely a “general hospital” to being an “Army Medical Center.” The sprawling complex, a Surgeon General’s report claimed, “acts as the central unit in the professional educational system of the Medical Department.” In the wake of the Great War, Walter Reed’s wards would serve not only as havens for the “treatment of the sick and wounded of the Army and discharged disabled soldiers,” but also for training programs geared at army medical officers, “hospital internes,” “enlisted specialists,” and

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<sup>34</sup> "Letter from Secretary of War Newton D. Baker, to the Attorney General", June 14, 1920. Records of the Adjutant General's Office, Central Decimal Files, 1917-1925, Hospitals St. Elizabeths Hospital to Walter Reed Hospital, Record Group 407, Box No. 1428, Folder 004.61 Walter Reed to 601.1 W.R., National Archives and Records Administration, College Park, Maryland.

<sup>35</sup> "Army Medical Plans and Needs Outlined by Surgeon General," *The Come-Back* August 21, 1920.

occupational therapists, among others.<sup>36</sup> World War I marked only the beginning of a long-term institutional expansion.

*A different interpretation of the hospital: Soldier complaints*

Some patients' perceptions of Walter Reed differed sharply from *The Come-Back's* portrayal of the hospital as the pinnacle of medical advancement, and a community of healing and learning. The Army Inspector General's Department investigated more than 20 complaints pertaining to conditions and patient treatment at the institution between February 1918 and October 1921. Many of these cases ended in absolution for the hospital, but some led the Inspector General to suggest that changes be implemented in its administration. Two investigations in particular – into laundry services provided at Walter Reed and rules regarding discharge – demonstrate that individual patients and their loved ones had anything but unquestioningly positive views of the care being provided by the military and government. Even during initial encounters with state-sponsored rehabilitation for the wounds and ills resulting from war, dissatisfaction was mounting among soldiers and their advocates. Service members expressed resentment at what they deemed low-quality hospital services, and at being discharged before they felt wholly self-sufficient; they faulted an army health system they argued was negligent. But army doctors, nurses, and other health officials defended the care being provided. They argued that they were forced to abide by vague policies in an over-extended medical system, and noted that ex-soldiers could turn to civilian entities upon release from service in order to obtain services.

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<sup>36</sup> Annual Report of the Surgeon General to the Secretary of War, 1926: Government Printing Office, Washington, D.C., 1926), 316.

A study of the testimonies gathered during these investigations demonstrates two things: first, it shows vast differences in expectations – and by extension, perceptions – of the nature and extent of governmental obligations to U.S. service members and veterans. Second, it highlights some of the main shortfalls of a rehabilitation effort centered in military facilities, and the root causes of the decision to establish a federally-sponsored hospital system tailored to the needs of ex-service members. Pre-war hopes that army medical services would serve any and all needs of injured and ill American Expeditionary Forces troops, the investigations show, had given way to bureaucratic realities.

“Fair play was we should have our clothes washed”: The extent of military obligations

On January 25, 1919, *The Washington Evening Star* ran a damning exposé regarding laundry service at Walter Reed. Some patients, the paper reported, wore the same undergarments for weeks on end because they lacked the physical ability, due to incapacity from injury or illness, to wash them. Some sent the clothing to be professionally laundered at their own expense. Others, lacking the funds to do so, were compelled to do their own washing in bathtubs. The upshot, according the *Star* was that many were forced to abandon wearing undergarments all together, and remain only in pajamas, since those could be laundered by the same hospital service charged with cleaning linens.<sup>37</sup>

The underwear the *Star* referred to was likely somewhat cumbersome to wash. According to two authors, the World War I era marked a transition in the history of men’s undergarments, when the popularity of the “union suit,” a full-length, long-sleeved bodysuit, was

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<sup>37</sup> Robert D. Palmer, "Inspector General's Department Investigation as to the Laundering of Clothing by Patients at Walter Reed General Hospital" January 31, 1919, 1. Office of the Inspector General Correspondence, 1917-1934, Record Group 159, Box 1110, Folder 12, National Archives and Records Administration, College Park, MD.

challenged. They contend that the turning point came about, in part, because A.E.F. soldiers were issued shirts and lightweight shorts as underwear – the precursor to boxer shorts, sometimes called “skivvies” by soldiers – rather than the union suit.<sup>38</sup> But Doran Cart, Senior Curator at the National World War I Museum in Kansas City, Missouri, points out that lightweight cotton shorts were issued primarily to soldiers stationed in the U.S. The most common type of underwear issued to soldiers serving on the front lines consisted of wool pants and wool long-sleeved shirts. A limited number of soldiers who served abroad, Cart says, were issued cotton pants and cotton long-sleeved shirts for wear in warmer weather. Given the fact that most of the Walter Reed patients who took issue with laundry services at the hospital had fought abroad, and some mentioned the idea that their underwear was comparatively warmer than pajamas, they were likely referring to long wool pants and a long-sleeved wool shirt.<sup>39</sup>

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<sup>38</sup> Gary M. Griffin, *The History of Men's Underwear: From Union Suit to Bikini Briefs* (Los Angeles, California: Added Dimensions Publishing, 1991), 35. Shaun Cole, *The Story of Men's Underwear* (New York, New York: Parkstone press, 2007), 58-70.

<sup>39</sup> Doran Cart, Senior Curator, National World War I Museum “Telephone Interview with Author,” (July 10, 2012) Also see: Doran Cart, “The Doughboys,” (Kansas City, Missouri: National World War I Museum).





*Soldiers who served abroad were typically issued heavy wool underwear, which injured patients at Walter Reed argued was difficult to wash by hand.<sup>40</sup>*

After the release of the *Star* story, the Inspector General's Department hastily conducted a follow-up investigation, which pointed out that of the 1,881 patients in the hospital, 1,054 were being treated for injuries or illnesses that did not involve amputations and were ambulatory; they were fully capable of doing their own laundry. Another 559 patients were amputees (267 arm and 332 leg amputees), of whom 450 were ambulatory. Testimony was collected from ten percent, or 45 of these ambulatory amputation cases, since the *Star* had focused on these men in its story.<sup>41</sup> Some patients had little in the way of complaints. Private Jim Pares, whose right arm and right leg had been amputated, said he wore pajamas because they were more comfortable

<sup>40</sup> Photos of U.S. issue underwear, from the collection of the National World War I Museum, Kansas City, Missouri. Photos by Doran Cart, Senior Curator, National World War I Museum.

<sup>41</sup> Palmer, "Inspector General's Department Investigation as to the Laundering of Clothing by Patients at Walter Reed General Hospital", 3-8.

given his physical condition. But he had no qualms with Walter Reed or its staff: "They treat me good," he said. "I can only kick for this leg, that is all."<sup>42</sup> Private Joseph Thibodeux said he would have preferred to wear underwear instead of pajamas, mostly because the former were warmer, but his pair disappeared after he washed them in the latrine and left them there to dry. He had been unable to secure others since.<sup>43</sup> Private Edward Stubbs, whose left arm had been amputated, said he was able to wash his handkerchiefs and socks, but that washing underwear, because it was comparatively larger, was impossible.<sup>44</sup> These men were reserved in their claims and complaints, merely stating the facts about the laundry situation, but replying that they had no official gripes about the hospital when asked outright by the Inspector. Private Ernest E. Birge, who had both of his legs amputated at the thigh, reported that it was "perfectly alright" that he had to wear pajamas temporarily while he awaited his laundry. He was fortunate enough to have his washing done by a local volunteer who decided to do her bit for wounded soldiers by washing their clothes.<sup>45</sup>

But a few who had not happened upon such resources spoke less blithely about their feelings. Private Samuel Ellis, a black soldier whose right arm had been amputated, explained to the inspector general that he was wearing pajamas because his only pair of underwear had disappeared after he washed them "with my one hand" and left them to dry. Following his

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<sup>42</sup> Inspector General's Department, "Testimony of Individuals Taken at Walter Reed General Hospital" January 29, 1919, 3. Ibid.

<sup>43</sup> Ibid., 36.

<sup>44</sup> ———, "Testimony of Individuals Taken at Walter Reed General Hospital" January 30, 1919, 55. Office of the Inspector General Correspondence, 1917-1934, Record Group 159, Box 1110, Folder 12, National Archives and Records Administration, College Park, MD.

<sup>45</sup> Ibid., 61. Birge's perspective reinforces Deborah Cohen's argument that the good will of fellow citizens, not necessarily the good will of governments, could ensure that disabled veterans remained "devoted subjects." See *Disabled Veterans in History* ed. David A. Gerber (Ann Arbor, MI: University of Michigan Press, 2000), 295-309.

detailed account, he was asked bluntly by the Inspector: “What did you report to me for?” Ellis answered with equal abruptness: “My complaint is no clothes, no underwear, no socks, bought my own socks and got no way to wash my clothes and can’t wring them out with one hand and there is no place to dry them in the ward.”<sup>46</sup> Private Owen McMahon, whose right leg had been amputated, spoke with similar urgency directly to the issue of whether patients should be held accountable for doing their own washing at all: “I was expecting that we should have all our clothes washed,” he said. “I thought that we had done our bit and fair play was we should have our clothes washed.”<sup>47</sup>



*Recuperating soldiers, wearing pajamas, at Fort McHenry*<sup>48</sup>

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<sup>46</sup> Department, "Testimony of Individuals Taken at Walter Reed General Hospital", 57.

<sup>47</sup> Ibid., 59.

<sup>48</sup> "Photo #13, Soldier-Patients at Fort McHenry", undated. Lynch Collection, Otis Historical Archives 220, Scrapbook, Occupational Therapy - photos of soldiers at Fort McHenry, 1918-1920, National Museum of Health and Medicine, Washington, D.C.

Although members of the staff of the hospital recognized the problem at hand and vowed that immediate action would be taken, they expressed shock and disappointment about the patient complaints. The 1917 annual report of Walter Reed Hospital lamented that there was a lack of storage space and transportation to provide for the tremendous increase in the amount of washing being done at the institution; approximately 34,000 pieces had been laundered in 1916, compared with almost 87,000 in 1917.<sup>49</sup> Major Francis Christian, hospital Quartermaster, noted that, in January and October of 1918, E.R. Schreiner, the Commander of Walter Reed, had requested that the Surgeon General authorize the expansion of laundry facilities at the hospital, but no action had been taken.<sup>50</sup> Schreiner himself reported the same to the Inspector General, adding that prior to the publication of the story in the *Star*, “no information of maimed patients doing their own washing had come to my attention.” Following the article’s publication, he noted, he had worked with Christian to arrange for patients’ laundry to be sent to Fort Meade in Maryland.<sup>51</sup>

Hospital staff never argued that patients deserved this service as an earned privilege; in this respect, there was a disconnect between what Walter Reed employees thought soldier-patients deserved, and what soldier-patients felt they were owed. In fact, hospital higher-ups had considered utilizing a private laundry service at the expense of the soldiers themselves, but Schreiner thought the record-keeping involved in such an endeavor would be overwhelming. As the logistics were worked out with Camp Meade, he ordered that a stock supply of underwear,

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<sup>49</sup> "Walter Reed Army General Hospital Annual Report for 1917", May 2, 1918, 2. Records of the Office of the Surgeon General, RG 112, Box 1, Entry 401, Folder: Annual Report 1917, National Archives and Records Administration, Washington, D.C.

<sup>50</sup> Major Francis Christian, "Investigation as to the Laundering of Clothing by Patients at Walter Reed General Hospital, Reply to Questions" January 29, 1919. Office of the Inspector General Correspondence, 1917-1934, Record Group 159, Box 1110, Folder 12, National Archives and Records Administration, College Park, Maryland.

<sup>51</sup> E.R. Schreiner, *Ibid.* January 28, 1919, 71-4. College Park, MD.

shirts, socks, and undershirts be kept at the hospital, for which patients could exchange soiled or worn items.<sup>52</sup>

The American Red Cross was also eager to step up. Edith Oliver Rea, Field Director of the organization's post at Walter Reed was regretful that neither she nor the women under her charge who visited patients in wards daily were aware of the situation. "Of course, we listen to a great many complaints of different kinds, but my orders to all my ladies have been not to encourage them in their grouches but to do everything in their power to help them; and I assure you that this thing was not brought to our attention," she told a representative of the Inspector General. Even as hospital higher-ups like Schreiner and Christian planned to offer a new laundry service through Camp Meade, Rea said the Red Cross would take written requests from patients for that organization to assist them with washing. It was important to get the requests in writing, Rea said, to avoid abuse of the system by "some of those lazy men would want to have their's (*sic*) done – you know, there are a great many men who want to accept favors without doing anything in return."<sup>53</sup>

Rea's statement alluded to a central principle of World War I-era reconstruction and a central issue in the broader (and ongoing) debate about models for hospital care in general: how to balance an institution's medical and social missions. World War I caregivers knew they had an obligation to help wounded and ill soldiers get physically better, but they faced a conundrum regarding the prospective role they should play in promoting self-reliance and a hasty return to

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<sup>52</sup> Ibid.

<sup>53</sup> Inspector General's Department, "Testimony of Individuals Taken at Walter Reed General Hospital" January 29, 1919, 32-3. Ibid. Rea is referred to in correspondence and publications as "Mrs. Henry Rea," rather than Edith Oliver Rea. She was an important and instrumental advocate for injured soldiers and is credited with the 1918 founding of the Red Cross' "Gray Ladies" volunteer service at Walter Reed. For more on the Gray Ladies at Walter Reed, see "Folder Regarding Red Cross Gray Ladies". Otis Historical Archive 355, Box 4, Folder: PAO File -- Red Cross, National Museum of Health and Medicine, Washington, D.C.

non-institutional, civilian life. The *Star* story neglected to convey the idea that allowing a soldier to do his own laundry could be seen as encouraging him to partake in activities essential to daily life. That was how Lieutenant Willard A. Widnew of the Sanitary Corps at Walter Reed saw it. He realized that the act of doing one's washing was a "hardship" for some soldiers, but "our attitude – at least my attitude – in regard to the one-armed men has been to regard them as nearly as I was able to as whole men and to put account on it (*sic*) in that he was able to do what other men were able to do, and although I have seen men have difficulty with their washing, but (*sic*) I felt that they would devise a way to do it and it was an instrument to assist us in the rehabilitation of the men."<sup>54</sup> Where, the question seemed to be, was the line between rehabilitative therapy and excessively high expectations? Hospital staff faced the difficult question of whether to treat patients as soldiers who should be subject to maximum discipline with limited individual rights, or as venerated citizens, who had done their bit and deserved special treatment.

In defense of Walter Reed's credibility, army brass and hospital administrators turned to two sensible explanations regarding oversights in laundry services. First, they said, Walter Reed was not originally intended to house a vast number of ambulatory patients and the proper resources had not been supplied for it to serve in that role. The facility was thus bound to encounter logistical challenges during war. Second, administrators argued that the rehabilitation project itself called into question the veracity of a government-sponsored laundry service that spurred laziness by freeing men from a responsibility they would likely have to take on in civilian life. Even as they attempted to absolve the institution of blame, however, administrators hastily implemented immediate changes to alleviate the situation.

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<sup>54</sup> Inspector General's Department, "Testimony of Individuals Taken at Walter Reed General Hospital" January 29, 1919, 47-8. Office of the Inspector General Correspondence, 1917-1934, Record Group 159, Box 1110, Folder 12, National Archives and Records Administration, College Park, MD.

In his summary of the investigation, the inspector general's representative noted that the negative publicity that came with the publication of the article was "greatly deplored" by Walter Reed staff and volunteers. "The hospital facilities were not designed with the idea that patients would do their own washing," he said. In peacetime, the vast majority of the patients were bed patients, and would be wearing convalescent suits, but under war conditions, many more patients were ambulatory and could wear their uniforms. The fact that existing regulations provided no means for men to have their clothes cleaned, other than by paying for them to be professionally laundered, or by doing the washing themselves, "had evidently not been given consideration in the hospital plans." In the end, the Inspector General reported, 20 of the men interviewed were found to have been doing their own laundry – mostly while seated at hospital bathtubs – while others either sent it out to be washed at their own expense, or opted to wear pajamas. Once the hospital Commander and the Red Cross became aware that the patients needed help, the inspector general reported, "immediate steps were taken to supply it."<sup>55</sup>

Their well-intentioned efforts aside, the inspector general's investigation highlighted the notion that the U.S. government was leaning heavily on military facilities to provide medical care (and living quarters, for that matter) for thousands of soldiers whose needs exceeded the services available to them. Soldiers' complaints about a lack of clean clothes expressed more than just frustration with a daily need unmet; they were a demonstration that military hospitals and their staffs were ill-equipped – physically and ideologically – to handle the long-term needs of chronic patients. Extended care, it was clear, would have to take place in a different sort of venue.

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<sup>55</sup> Robert D. Palmer, "Inspector General's Department Investigation as to the Laundering of Clothing by Patients at Walter Reed General Hospital" January 31, 1919, 4-8. Ibid.

*“Until some provision is made I do not wish to be separated from the army”: Complaints about discharge*

In spite of complaints about conditions at Walter Reed, some soldiers were eager to prolong their stays there. An investigation into claims of patients who felt they were being prematurely discharged from the facility shows that pre-war plans not only placed a heavy weight on military hospitals, but that they also left up to interpretation the question of when a soldier was, to use the words of pre-war legislation pertaining to the issue, “functionally restored as far as possible.”<sup>56</sup> Many soldiers strove for a hasty discharge from service and a return to civilian life, but some others complained they were rushed out of the army – and its hospitals – before they were physically capable of taking care of themselves. The disgruntled soldiers’ cause was taken up by South Dakota Republican Congressman Royal C. Johnson, whose May 1920 letter to the Secretary of War resulted in a six-month inspector general’s investigation into matters of premature discharges and neglect at Walter Reed Hospital.<sup>57</sup>

There were hints immediately following the Armistice that the rehabilitation project would be complicated by rules regarding when and how to release soldiers from service. In December 1918, the army, eager to rid itself of the responsibility of caring for patients who pined for home and resisted military dictates and discipline, modified its discharge policies. The War Department allowed service members who furnished documents showing they could access necessary care outside of the army to be released. According to the rules of such a discharge, the Secretary of War was thereafter released from any further responsibility for treatment. The army

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<sup>56</sup> A.G. Crane, *The Medical Department of the United States Army in the World War; Volume 13, Part One: Physical Reconstruction and Vocational Education*, ed. M.W. Ireland (Washington, D.C.: Government Printing Office, 1927), 30-31.

<sup>57</sup> C.C. Kinney, "Report of Investigation Concerning the Treatment and Discharge of Patients at Walter Reed General Hospital" November 15, 1920, 1. Office of the Inspector General Correspondence, 1917-1934, Record Group 159, Box 1110, Folder 18, National Archives and Records Administration, College Park, MD.



policy stemmed from “an anxiety to be discharged among both officer and enlisted patients that amounted almost to hysteria and was universal...”<sup>58</sup>

But the reasoning for seeking discharge could extend beyond a desire to be free of army discipline and hierarchy, and have to do with a hankering for control over the nature of medical care one could receive. Ralph Williams, who had been badly wounded in France, was one of those who rejected treatment and opted to be released from the military. “When I went before the examining board, they said I was to go to Walter Reed Hospital for possible surgery,” Williams reported. “I said I did not wish to have that done and explained that I had been told not to rush into it.” Williams’ dissent, he implied, brought about some hostility. “They informed me that I was still in the army and subject to their orders.... I was told that if I did not agree to the surgery I would have to sign waivers of any further claim against the government. That is what I did.”<sup>59</sup>

The fear of contemporary observers that the new discharge rules would mean that “the majority of the disabled would return to civil life in a physically unfit condition rather than in the best condition possible... thereby completely destroying the general utility of the entire reconstruction program,” ultimately proved prescient.<sup>60</sup> Although the 1918 discharge rule released the army from further obligations to injured and ill ex-service members like Ralph

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<sup>58</sup> The quote is from Crane, *The Medical Department of the United States Army in the World War; Volume 13, Part One: Physical Reconstruction and Vocational Education*, 49. On the roots of and rationale behind the policy, see “Memorandum for the Adjutant General Regarding Discharge of Disabled Soldiers, from Henry Jervoy, Major General, Assistant Chief of Staff, Director of Operations”, December 17, 1918, 2. Records of the War Department, General and Special Staffs, Correspondence of War College Division and Related Gen. Staff Offices, 1903-1919, Record Group 165, Microfilm 1024, Roll 346, National Archives and Records Administration, College Park, Maryland. For more on changing discharge rules, see Chapter One.

<sup>59</sup> Ralph L. Williams, “The Luck of a Buck” 1984. World War I Veterans Survey, 2nd Division, 2nd Engineer Regiment, Company A, Folders 2 and 3, Army Heritage and Education Center, U.S. Military History Institute Archives, Carlisle Barracks, Carlisle, PA.

<sup>60</sup> Crane, *The Medical Department of the United States Army in the World War; Volume 13, Part One: Physical Reconstruction and Vocational Education*, 49.

Williams, it was ultimately decided that it did not release civilian governmental agencies from the same.

For those who did seek care in military hospitals, the discharge process could be complex and lengthy. In 1920, the typical procedure for a soldier's discharge from Walter Reed, according to Major Lucius L. Hopwood, the hospital's Supervisor of Clinical Records, began when the Chief of the Medical or Surgical Service decided that a patient had come as close to maximum improvement as could be expected. The Ward Surgeon then proceeded to seek clearance from the chiefs of various services who had been involved in the treatment of the soldier, before working with the Section Chief to fill out discharge papers indicating, among other things, a disability rating and a judgment as to "whether or not further treatment is considered necessary (and) whether or not the maximum degree of improvement has been attained."<sup>61</sup>

Soldiers and officers had limited say in the discharge process. As the Section Chief circulated the proper paperwork, hospital officials sent written notice to the patient that his discharge was being "contemplated" to take place two weeks from the date of notification. He was also told to appear before the hospital board for a physical examination.<sup>62</sup> In the Spring of 1920, one soldier's Medical Board proceedings included four Board members: Lucius Hopwood, William L. Keller, Chief of the Surgical Service at Walter Reed, and two other, high-ranking army doctors and Medical Corps members.<sup>63</sup> If an officer was found to have a disability, or

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<sup>61</sup> Inspector General's Department, "Sworn Testimony of Lucius L. Hopwood, Major, Medical Corps, Taken at Walter Reed General Hospital by Lieut. Colonel C.C. Kinney, I.G.D. " August 5, 1920. Office of the Inspector General Correspondence, 1917-1934, Record Group 159, Box 1110, Folder 18, National Archives and Records Administration, College Park, MD.

<sup>62</sup> Ibid.

<sup>63</sup> Walter Reed Army General Hospital Medical Board, "Board Proceedings (Re. The Case of George B. Russo)" May 3, May 7, June 1, 1920, Ibid. College Park, Maryland.

claimed to have a disability, or if he objected to his discharge, he could bring his case to a “board of review.” According to Hopwood, officers and enlisted men sat in on review board proceedings concerning their own cases and received an opportunity to share their opinions. But they were excused from the room when the doctors discussed the issues of greatest concern: the degree of disability and whether or not a disability would be listed on discharge papers as having been contracted in the “line of duty.” Once release from service was agreed upon and mandated, a soldier would be physically examined one last time – no more than 24 hours before his actual discharge.<sup>64</sup>

Some soldiers testified that the process was not so systematic or fair. Complaints made about early discharge hinted at dissatisfaction with the quality of care offered at Walter Reed, but even more so at a sense of dejection about the prospects men thought they faced following their stays there.

Lieutenant Arthur L. Chamberlain, for example, suffered from bronchitis, insomnia, and psychoneurosis after his boat was torpedoed off the coast of Ireland and he waded in the water for hours. Following five months of treatment at Walter Reed, Chamberlain was discharged with a disability rating of 15 percent in March 1920. A few days before his scheduled separation from service, he wrote to Hopwood: “I have asked to be discharged March 15<sup>th</sup> as I cannot see the use of staying around the hospital without improvement in my condition, however when I made this request I expected to be taken care of after leaving the service.” Chamberlain withdrew his request for discharge, implying that his condition was as bad, if not worse than those who had received ratings of total permanent disability. “Until some provision is made I do not wish to be

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<sup>64</sup> Inspector General's Department, "Sworn Testimony of Lucius L. Hopwood, Major, Medical Corps, Taken at Walter Reed General Hospital by Lieut. Colonel C.C. Kinney, I.G.D. " August 5, 1920, Ibid. College Park, MD.

separated from the army,” he wrote. “I have a wife and two children to support but as I cannot do anything for them I don’t know what to do but to commit suicide and end it all.”<sup>65</sup>

By minimizing the degree of his injury, according to Chamberlain, the army had hindered his ability to support his family. The soldier’s plea was presented to a later disability board, which maintained the 15 percent decision, and released him from the army. Under review by the Bureau of War Risk Insurance, the Treasury Department agency created to administer insurance and disability compensation payments to World War I veterans, the rating was increased to total temporary disability, which bolstered the veteran’s charge that Walter Reed administrators had been merciless. After being evaluated by the Public Health Service, the federal entity that assumed control of administering medical care to veterans once they were discharged from the army, he said: “I have been told I have not reached maximum improvement, but that I was curable and would be all right in time.”<sup>66</sup>

Lieutenant William H. Vail also argued that his subsequent treatment by the Public Health Service justified his claim that he had been prematurely discharged from the army. Vail, who was treated at Walter Reed from March 1919 through April 1920, had his left leg amputated

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<sup>65</sup> According to the War Risk Insurance Act, a discharged soldier could receive one of four possible disability ratings: total temporary, total permanent, partial temporary, or partial permanent. In the case of the latter two ratings, the veteran was assessed with a certain percentage of disability. Hearings before the Subcommittee of the Committee on Appropriations, United States Senate, H.R. 13870, Sixty-Sixth Congress, Second Session, (Washington, D.C.: Government Printing Office, May 14, 1920), 5-8. For more on ratings, see Chapter Four. The quotes are from ———, “Letter from Arthur L. Chamberlain, 1st Lt. Engrs., Ward 23 to Lucius Hopwood, Supervisor of Clinical Records, Walter Reed Army General Hospital” March 13, 1920. Office of the Inspector General Correspondence, 1917-1934, Record Group 159, Box 1110, Folder 18, National Archives and Records Administration, College Park, MD. Also see ———, “History of the Case, Obtained from the Officer, Lieut. Arthur L. Chamberlain”. Office of the Inspector General Correspondence, 1917-1934, Record Group 159, Box 1110, Folder 18, National Archives and Records Administration, College Park, MD.

<sup>66</sup> Inspector General’s Department, “Letter from Arthur L. Chamberlain to Major C.C. Kinney, Inspector General’s Department Re. Treatment at Walter Reed Hospital” July 16, 1920. Office of the Inspector General Correspondence, 1917-1934, Record Group 159, Box 1110, Folder 18, National Archives and Records Administration, College Park, MD. Medical care under the BWRI and PHS, as well as rules about compensation and discharge, will be further discussed in Chapter Four.

below the knee and a fracture of the frontal bone of his head, which resulted in a depression in his skull. Vail was relatively satisfied with the treatment he received for his leg, but reported: "I was very much afraid of my head, knowing that it involved the brain. I wanted everything to be just as good as possible, and I felt that the conditions (at Walter Reed) were not such..." Several times, Vail asked for the authority to consult with specialists at Johns Hopkins Hospital. "I lost confidence in the surgeons at (Walter Reed)," he said. "They did not seem to get down to brass tacks." In spite of his desire to seek medical care outside of the military hospital, Vail protested his certificate of discharge, which he said came "out of a clear sky." He was not ready to leave the service, he said.<sup>67</sup> But Colonel William L. Keller, Chief of the Surgical Service at Walter Reed claimed that army doctors offered to perform the head surgery for Vail, and that once he declined, they assessed that he had reached maximum improvement and should be discharged from the army.<sup>68</sup> Soon after the soldier's discharge, a Boston surgeon operated on Vail, telling him the surgery was unavoidable. Vail reported to the inspector general that his expenses in Boston were covered by the Public Health Service, which "was all very satisfactory, but I constantly felt I should not have been discharged until this had been done."<sup>69</sup> Like Chamberlain, Vail believed that, given the fact that he had entered the service self-sufficient and whole, he should remain under the army's auspices until his post-service condition was unquestionably stable.

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<sup>67</sup> ———, "Testimony of William H. Vail... Taken in Office of Department Inspector, Central Department, Chicago, Ill., Sworn to Captain W.M. Robertson, Inspector General" July 29, 1920. Office of the Inspector General Correspondence, 1917-1934, Record Group 159, Box 1110, Folder 18, National Archives and Records Administration, College Park, MD.

<sup>68</sup> ———, "Sworn Testimony of William L. Keller, Medical Corps, (Continued)", 4. Office of the Inspector General Correspondence, 1917-1934, Record Group 159, Box 1110, Folder 18, National Archives and Records Administration, College Park, MD.

<sup>69</sup> Inspector General's Department, "Testimony of William H. Vail... Taken in Office of Department Inspector, Central Department, Chicago, Ill., Sworn to Captain W.M. Robertson, Inspector General".

Lieutenant John Henry Gose claimed, like Vail, to be satisfied with the treatment he received for one injury, but not others. A flying accident in England led to the amputation of the pilot's right leg, and severe burns on the left. Gose also said he had fractures and a lack of circulation in his left ankle, a stiff jaw, and partial deafness. Fitted with a temporary limb at Walter Reed, Gose said he had few complaints about his overall treatment. "The only problem was the attitude to the ankle," he said. In March 1919, hospital administrators recommended he be discharged, but he refused to sign the papers until his ankle was X-rayed. Once this was done, hospital officials agreed an operation was necessary, but said that the soldier's circulation had to be improved before it could be performed. For six months, Gose received massage treatments to these ends, but when the head of the Orthopedic Service was replaced by a new staff member, he said he was abruptly notified that "I received my maximum improvement... even though I expressed myself as feeling that I had not received my maximum improvement." Like Chamberlain and Vail, Gose's original army disability rating of 70 percent was eventually increased by the Bureau of War Risk Insurance to total permanent disability. When asked about the extent of treatment offered to the soldier, both Marion R. Mobley, the new head of Walter Reed's Orthopedic Section, and Lucius Hopwood, the Supervisor of Clinical Records, stood by the decision that he had reached maximum improvement by the time he was discharged.<sup>70</sup>

Private George B. Russo, like his fellow patient, Arthur Chamberlain, expressed his desire to be discharged from the hospital, but later testified that his release was premature, given the sudden challenges he faced upon being released. A patient at Walter Reed from February 1919 through his discharge from the army in May 1920, Russo, whose left leg had been

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<sup>70</sup> Inspector General's Department, "Sworn Statement of John Henry Gose, Taken by Major C.C. Kinney, I.G., at Washington, D.C." June 14, 1920. Office of the Inspector General Correspondence, 1917-1934, Record Group 159, Box 1110, Folder 18, National Archives and Records Administration, College Park, MD.

amputated, contended: "I did not want to stay in the hospital; I want to get into civilian life." But when his stump became infected and blistered immediately prior to his scheduled discharge date, he said, "I told them I was not fit to go out." Russo had only been walking on his temporary limb for two weeks and felt he was "not able to get around very well." When asked explicitly by the inspector general why he had not signed his discharge papers, Russo said, "my stump would not allow me. I have to earn my living when I get out, and I cannot put any weight on my leg." After being released from service, Russo was immediately re-admitted to Walter Reed Hospital as a patient of the Bureau of War Risk Insurance. In that capacity, he remained in bed and received inoculations intended to fortify his blood so his stump would become strong enough to support his prosthetic limb.<sup>71</sup>

In response to the claims of premature discharge, army officials and Walter Reed doctors reported that they adhered to pre-war policies regarding maximum improvement. They referred the inspector general to a clause stating that, "The President is authorized and directed to retain in service disabled emergency officers until their treatment for physical reconstruction has reached a point where they will not be further benefitted by retention in a military hospital or in the military service." Army Surgeon General Merritte W. Ireland reported that he interpreted that clause to mean:

When it becomes clear that the condition of any officer patient is growing worse month by month, and when it is apparent for a period of several months that no improvement is being made, and when in other instance (*sic*) the patient's condition fails to furnish any grounds for expecting improvement in the future, then I believe his treatment for physical reconstruction has reached a point when further benefit can not be expected by his retention in military

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<sup>71</sup> ———, "Sworn Testimony of Pvt. George B. Russo... Taken at Walter Reed U.S. Army General Hospital, by Major C.C. Kinney, I.G." May 26, 1920. Office of the Inspector General Correspondence, 1917-1934, Record Group 159, Box 1110, Folder 18, National Archives and Records Administration, College Park, MD.

hospital or in the military service. Consequently his discharge is indicated under the provisions of the law.<sup>72</sup>

Colonel William L. Keller, Chief of the Surgical Service at Walter Reed concurred, and offered a further explanation. Once medical treatments ceased being effective, he said, “the depressing atmosphere of a hospital is injurious to the patient.”<sup>73</sup> According to Ireland and Keller, then, if a soldier’s medical condition was worsening, he should be discharged from the army hospital.

The Army Medical Department thus only deemed itself responsible for patients so long as they were improving, and demonstrating that they were being actively reconstructed. Ireland said as much in a letter to Democratic Senator Charles Thomas of Colorado: “To retain all patients indefinitely... would require the continued maintenance of large military hospitals with the necessary medical personnel and material; for such a procedure, the Medical Department appropriations are not sufficient.” Furthermore, Surgeon General Ireland noted, the Bureau of War Risk Insurance boasted “abundant facilities for the care of officers and soldiers, and it is my firm belief that when the Medical Department of the Army has achieved all that can be expected in the way of the physical reconstruction of our military personnel... the individual should be discharged from the military service and should pass into the care of that Bureau.”<sup>74</sup>

Army officers followed this plan in the immediate post-war years, discharging those with chronic ailments or injuries that were slow to heal to the auspices of the Bureau of War Risk

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<sup>72</sup> Inspector General of the Army, "Report of Investigation into Alleged Premature Discharge of Patients from the Walter Reed General Hospital and to the Alleged Failure of the Bureau of War Risk Insurance to Care for These Patients." November 23, 1920. Office of the Inspector General Correspondence 1917-1934, RG 159, Box 1110, National Archives and Records Administration, College Park, MD.

<sup>73</sup> Department, "Sworn Testimony of William L. Keller, Medical Corps, (Continued)", 3.

<sup>74</sup> Inspector General's Department, "Letter from M.W. Ireland to Honorable C.S. Thomas, U.S. Senate" July 29, 1920. Office of the Inspector General Correspondence, 1917-1934, Record Group 159, Box 1110, Folder 18, National Archives and Records Administration, College Park, MD. For a discussion of changing discharge rules, see “Pervasive policy limitations and questions: Discharge and ‘line of duty’ injuries,” in Chapter One of this dissertation.



Insurance and the Public Health Service, sometimes to the chagrin of patients themselves, who balked at the idea of being sent into the civilian world with what they saw as a lack of guaranteed income or follow-up medical care. With no other definitive entity to turn to, they occasionally blamed the Army Medical Department for their troubles. While Walter Reed Hospital Commander James D. Glennan substantiated the claims of others interviewed that it was much more common for soldiers to fight to hasten discharge than it was for them to try to delay it, he did concede that it was “very common” for servicemen to object to their discharge, implying that such objections stemmed from fear or intimidation. “A certain type of officer after being in hospital a year or two years – sick in hospital – does not wish to leave the hospital to go into the world again to take up life outside.”<sup>75</sup>

The inspector general’s final report about the investigation into premature discharges concurred with the claims of some army officials that patients’ complaints were spurred mainly by a desire for higher disability payments and not by legitimate gripes with the system. “No branch of the government has been confronted with such an important, humanitarian and gigantic task since the signing of the armistice as the Medical Department of the army,” the report concluded. “Errors of judgment have probably occurred,” it said, but that was understandable, given that “thousands” were “passing through the hospital for treatment.” The report noted caustically that it was “difficult to conceive of patients who have been treated... for a long period not being appreciative of what was done for them.” Perhaps, it postulated, “the disability rating

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<sup>75</sup> ———, "Sworn Testimony of James D. Glennan, Colonel, Medical Corps, Taken at Walter Reed General Hospital by Colonel C.C. Kinney, I.G.D. " August 5, 1920, 4. Office of the Inspector General Correspondence, 1917-1934, Record Group 159, Box 1110, Folder 18, National Archives and Records Administration, College Park, MD.

fixed by the medical boards is the real basis for the majority of these complaints, the patients believing that they deserved a higher rating than was awarded them...<sup>76</sup>

The report overlooked the fact that the soldiers' complaints indicated something that might have gone beyond their "not being appreciative of what was done for them."<sup>77</sup> Glennan's response to Russo's testimony, for example – which pointed out that the soldier could seek help through the Bureau of War Risk Insurance for continuing maladies – revealed a gaping distance between soldiers' desires for and expectations of self-sufficiency, and the credo of "maximum improvement" adhered to by the Army Medical Department.<sup>78</sup> Keller, of the Surgical Service, frankly stated that the military hospital could only help soldiers progress up to a point, but that "it will take two years before these patients reach maximum improvement."<sup>79</sup> Private Jeremiah J. Hurley, on the other hand, declared that "when I leave this hospital I do not want to have to enter any other hospital for treatment."<sup>80</sup> In his commentary regarding Hurley, the Inspector General had remarked caustically that when the veteran's disability status was raised from 100 to 200 percent (and his monthly payments thus doubled), "all his complaints seem to have

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<sup>76</sup> C.C. Kinney, "Report of Investigation Concerning the Treatment and Discharge of Patients at Walter Reed General Hospital" November 15, 1920, 13-14. Ibid. College Park, MD.

<sup>77</sup> Inspector General's Department, "Report of the Investigation into Alleged Premature Discharge of Patients from the Walter Reed General Hospital and the Alleged Failure of the Bureau of War Risk to Care for These Patients" November 23, 1920, 8. Ibid.

<sup>78</sup> ———, "Sworn Testimony of James D. Glennan, Colonel, Medical Corps, Taken at Walter Reed General Hospital by Colonel C.C. Kinney, I.G.D. " August 5, 1920. Office of the Inspector General Correspondence, 1917-1934, Record Group 159, Box 1110, Folder 18, National Archives and Records Administration, College Park, MD.

<sup>79</sup> Department, "Sworn Testimony of William L. Keller, Medical Corps, (Continued)", 3.

<sup>80</sup> Inspector General's Department, "Sworn Testimony of Private Jeremiah J. Hurley... Taken at Walter Reed U.S.A. General Hospital, by Major C.C. Kinney" June 6, 1920. Office of the Inspector General Correspondence, 1917-1934, Record Group 159, Box 1110, Folder 18, National Archives and Records Administration, College Park, MD.

disappeared.”<sup>81</sup> In fact, Hurley, who had both his legs amputated, testified that, “what I want is justice in this disability... as I need a constant attendant after discharge, (and) the allowance of twenty dollars per month is not considered sufficient for one, I would therefore demand a rating of double total disability.”<sup>82</sup> For Hurley, higher disability payments meant a higher degree of self-sufficiency and a greater chance that institutionalization could be avoided.

Similarly, Chamberlain, Gose, Vail, and Russo all wanted to be discharged from the army only when they felt they had the ability and resources to take care of themselves. Army higher-ups, on the other hand, conceived of the military hospital as a first stop in an occasionally ongoing rehabilitation process. Soldiers’ expectations for their quality of life upon discharge conflicted with the army’s interpretation of vague policies regarding “maximum improvement.” The ideological divide led to hostility and resentment from soldiers who felt that the army in which they had served and sacrificed was cutting them off prematurely.

Both doctors and patients resisted embracing hospitals as ideal venues for long-term care, but for many, they became a seemingly inevitable choice. As military hospital administrators discharged patients who they argued had either reached “maximum improvement,” or whose

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<sup>81</sup> C.C. Kinney, "Report of Investigation Concerning the Treatment and Discharge of Patients at Walter Reed General Hospital" November 15, 1920, 12. Ibid.

<sup>82</sup> Inspector General's Department, "Sworn Testimony of Private Jeremiah J. Hurley... Taken at Walter Reed U.S.A. General Hospital, by Major C.C. Kinney" June 6, 1920. Ibid. Hurley was not the only one who believed that government assistance for veterans was a form of “justice” and not charity. At a June 1921 convention of the Disabled American Veterans (an organization which will be discussed in detail in Chapter Five), a veteran from California voiced his support for government provision of land and home loans by saying: “I do not feel that the government of the U.S. owes me a permanent living, but I do feel that the government owes me a lasting duty to stand behind me as long as I endeavor to help myself and that duty ceases only when I have demonstrated that I have returned to that state of independence I previously enjoyed. We ask not for coddling but for justice. We request not alms, but that which by the grace of god is rightfully our due, namely assistance.” At the convention, the remarks received great applause. "Proceedings of the First National Convention of the Disabled American Veterans of the World War, at the Chamber of Commerce, Detroit, Michigan", June 28-30, 1921. Proceedings of National Conventions, Copy held by author, Disabled American Veterans National Headquarters, Cold Spring, Kentucky.

condition had ceased to improve, and as ex-servicemen who had never received care from the Army Medical Department – either by choice, or because their health maladies arose after service – came forward seeking care, the number of war veterans falling under the auspices of the Bureau of War Risk Insurance, and seeking attention from civilian entities such as the Public Health Service, increased.

The investigations into care offered at Walter Reed illuminate several important realities of World War I-era military and veterans' health care. Army officials had limited resources at their disposal as they attempted to foster principles much emphasized by contemporary reconstruction experts, such as self-reliance and a hasty return to civilian life. The pre-war policies army doctors were obliged to follow defined the military medical service as the entity most directly responsible for soldiers' recovery, but were also vague enough that they were open to interpretation. The question of when a soldier reached "maximum improvement," for example, came to mean that any sick or disabled soldier who was not physically improving was discharged from the hospital and often, from the military. After all, army officials argued, facilities like Walter Reed Hospital were not intended as sites for the provision of long-term medical care; the United States military could not spend its time and resources rehabilitating soldiers who would likely never serve again.

Meanwhile, injured soldiers had a very different perspective. Some felt that the government owed them not only the simple courtesy of laundry service, but that it also should return them to civilian life in much the same condition as they had been in when they entered the army. They resented being discharged physically compromised and therefore with no guaranteed source of a reliable income. As wounded soldiers became civilian citizens, they struggled to re-define their societal roles and responsibilities. The claims of men like Ellis and Russo, which

gained power as soldiers organized into veterans' advocacy groups, demonstrated that although extended government benefits and medical treatment were the antithesis of pre-war rehabilitation ideals focused on recovery, cure, and self-reliance, they were, in many cases, unavoidable.

The institutional coverage of *The Come-Back* and the patient complaints, of course, represent two extremes of opinion. A great many saw Walter Reed neither as the paradise portrayed by the newspaper or the perdition alleged by some, but instead, as a site of "sober reflection" where one could begin to learn how to cope with new physical realities.<sup>83</sup> The contrast between *The Come-Back* and the allegations against the hospital demonstrate that although the Army Medical Department predominantly fulfilled – in some ways, went beyond – the task set out for it by law to maximally rehabilitate wounded soldiers, its efforts were often seen as insufficient. Eager to embrace an identity as a "new army" that viewed the soldier as a whole man, not just as fodder for fighting, army officials attempted to ensure that medical services would live up to elevated expectations. But they ultimately resisted becoming ensnared in the administration of long-term after-care. By the early 1920s military officials, the government, and veterans – whether or not they felt army hospitals had adequately served the purpose set out for them by Congress in 1917 – all understood one thing: the facilities could not, in many cases, serve as the endpoint of care.

#### The Come-Back and a "manifestly unsatisfactory" situation

Reflecting this reality, *The Come-Back's* coverage of the nature of the military hospital expanded from a celebration of camp-like cheer and a promotion of professional military medicine, to include a frank representation of recovery as a somewhat painful process. By 1920,

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<sup>83</sup> See the discussion of Paul A. Bazaar's case earlier in this chapter. "He 'Comes Back' by Aiding Folks with Income Tax."

Walter Reed's wards had been emptied of all but the most drastically ill and injured A.E.F. soldier-patients, and *The Come-Back*'s parochial tone of promotion was relatively less pronounced. Its editors' growing respect for realism signified what was occurring among representatives, bureaucrats, and army staff in the halls of Congress, as well as among the general public: a coming to terms with the lasting and unpleasant effects of war. To be sure, until its final issue was published in March 1921, *The Come-Back* featured its fair share of sunny stories about sports events, holiday celebrations, and the actions of generous private citizens and welfare organizations. But by 1920, the heady post-war days had given way to a new sense of practicality, which reflected the fact that, for many patients, rehabilitation and recovery would be life-long endeavors. *The Come-Back* mixed informational and propagandistic missions in its coverage of government benefits and the future of medical care for disabled soldiers and veterans. It bolstered the idea that the government was willingly assuming its rightful obligation to provide health treatment and occupational training to the war-wounded, and ran detailed articles explaining how soldiers could access such assistance. But as ex-soldiers encountered difficulties while attempting to take advantage of benefits being offered, it became increasingly difficult to ignore the system's shortfalls. Initially taking a defensive stance against emerging complaints about bureaucratic "red tape," by late 1920 and early 1921, *The Come-Back* covered what were, by then, frequent legislative battles over expanding hospital access for wounded and ill ex-service members. The newspaper's editors gradually began acknowledging that the future of medical care for disabled veterans constituted a central political concern. Articles in *The Come-Back* highlight some of the complex, emerging bureaucratic and policy-centered issues surrounding the issue of veterans' medical care.

Beginning in the winter of 1919-1920, articles and poems in the newspaper occasionally included hints of some of the hardships involved in injury, illness, and recovery. A writer, who referred to himself only as “Ex,” for example, attempted to explain the nature of the Spanish flu. “It is by misery out of despair it pulls your teeth and curls your hair / it thins your blood and brays your bones; and sometime, maybe you get well / some call it Flu – I call it hell!”<sup>84</sup> Ex’s tone contrasted sharply with the tales of independent victory of will over illness put forth in earlier articles. In February 1920, *The Come-Back* published a raw expression of candor in the form of a letter from patient W.B. Felger, who had lost his left ear during the war. “Of the various kinds of injuries sustained from and as a result of the war,” Felger wrote, “perhaps none are more noticeable or cause more comment than those of the face and head.”

In all sorts of places and under all circumstances scarcely a person, from mere children to mature men and women, including the poorest observers, failed to notice my disfigurement, and in most cases I received a very searching look and thorough investigation. Of course such a state of affairs naturally would embarrass one meeting people day after day and one is inclined somehow to harbor a feeling almost like guilt as everyone looks at you as if they thought that you had committed a crime or just returned to civilization after serving a penitentiary sentence. In still another way I have found that occasionally, in coming in contact with people socially, there are some who will shun you – not because they dislike you, but they simply cannot look at disfigurements of any sort and feel at ease. A horror comes into their minds which forces them to avoid your presence. Naturally such a condition has decided disadvantages. It bars you from meeting certain people who would like to talk with you and, at the same time, you feel a little hesitant toward imposing yourself upon those who, you feel, might be sensitive to such things...

The overall tone of Felger’s letter, however, was positive. He was writing to thank Walter Reed’s museum curator, who had fashioned for him a prosthetic ear made of wax, which was “an exact duplicate of my right ear in shape and general appearance.” Only the “keenest observers,” said Felger, could notice that the ear was not his own. “One can hardly imagine the relief that

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<sup>84</sup> "Letters to the Editor," *The Come-Back* February 11, 1920.

came to me when I began the use of the artificial ear... there are now none of those looking after me with glances and looks which seem to haunt one from morning till night.”<sup>85</sup> In spite of the relatively happy ending, Felger’s frank representation of the experience of disability contrasted greatly with the coverage featured in earlier editions of *The Come-Back*, which focused heavily on a “will to win the battle of life.”<sup>86</sup>

An October 1920 article in *The Come-Back* signified that the army perceived a turning point, and was ready to relinquish its responsibility for war-wounded veterans. Beginning as a tribute to the accomplishments of the Army Medical Department, the article ended with a declaration that “many discharged soldiers still require hospital treatment, and many others will at some future time require treatment for conditions resulting from their military service.” The administration of care for such cases, the newspaper noted “does not devolve upon the War Department, but by law is placed in the hands of the Bureau of War Risk Insurance.” Citing examples of the vast success of the Army Medical Department during the war – the creation of military hospital complexes that featured entertainment for soldiers and their visiting loved ones, an array of training courses, and innovations in medical treatment for amputations, speech defects, facial injuries, and training for the blind – *The Come-Back* declared: “The work of the War Department in caring for the victims of the World War is practically finished.”<sup>87</sup>

The declaration may have seemed unsettling to patients who read the newspaper just a year or two earlier, and who were constantly reassured that various government entities (including the army) would indefinitely provide and any and all necessary care for them. In late

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<sup>85</sup> "Master Work Gains Praise from Patient," *The Come-Back* February 11, 1920.

<sup>86</sup> "Front Page Cartoon Caption," *The Come-Back* December 4, 1918.

<sup>87</sup> "Rehabilitation of Disabled Vets Subject of Careful Analysis," *The Come-Back* October 2, 1920.



1918 and early 1919, the news was, in many ways, good for troops being treated in military hospitals, according to *The Come-Back*. A letter from President Woodrow Wilson to Dr. C.A. Prosser, the Director of the Federal Board for Vocational Education, the entity charged with organizing efforts to provide vocational training to discharged soldiers, encapsulated one of the primary messages of the hospital newspaper: "This nation has no more solemn obligation than healing the hurts of our wounded and restoring our disabled men to civil life and opportunity," Wilson wrote. "The government recognizes this, and the fulfillment of the obligation is going forward fully and generously." Providing medical care and vocational education for wounded veterans, the President argued, was not charity, but "the payment of a draft of honor which the United States of America accepted when it selected these men, and took them in their health and strength to fight the battles of the nation."<sup>88</sup> His words succinctly summarized a message *The Come-Back* hoped to communicate to readers. An editorial praising Wilson's strong stance for the war-wounded noted that although the placement of disabled men in industry had become a "much bigger task than was anticipated at the time of the signing of the Armistice," the challenge was being met heartily by a grateful government.<sup>89</sup> A cartoon published in January 1919 echoed the sentiment:

"Ain't it a grand and glorious feeling... after you've been wounded and you stay in a hospital in France several long and weary months... and when you land in the USA you can't join the hurrah crowds... and you go to another hospital here not caring what happens because you'll never be able to earn a living without your right arm... and the government tells you it will teach you a new trade without charge... and finally you are all fixed and get a better job than you ever had – also your compensation and insurance and everything... oh-h-h boy!!! Ain't it a gr-r-r-rand and glor-r-rious feelin'"<sup>90</sup>

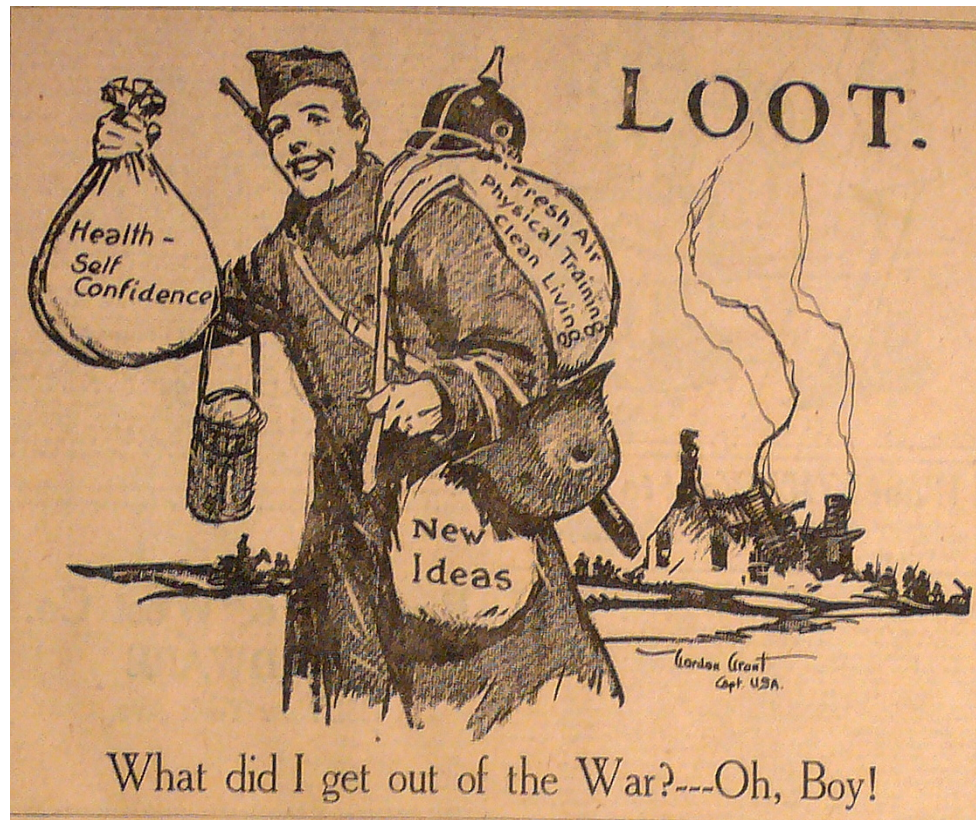
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<sup>88</sup> "President Wilson's Message on Healing the Hurts of Our Wounded," *The Come-Back* December 24, 1918.

<sup>89</sup> "Uncle Sam Is Squarely Behind Disabled Soldiers," *The Come-Back* December 24, 1918.

<sup>90</sup> "Ain't It a Grand and Glorious Feeling," *The Come-Back* January 8, 1919.

Similarly reassuring pieces were consistently published throughout the post-war years. Service members' bodily sacrifice was noble, justified, and worthwhile, the newspaper argued; the U.S. government and citizens would provide them the support necessary to facilitate their entry back into society.



The Come-Back, January 8, 1919<sup>91</sup>

As patients transitioned from soldier to veteran, they were meant to feel both self-sufficient and entitled. "Never before in the history of the world's warfare have such extensive plans been laid out for the benefit of the men disabled in conflict as those which are now in operation and others being formulated," the newspaper reported in May of 1920. "With practically no precedent to

<sup>91</sup> "What Did I Get out of the War?," *The Come-Back* Vol. 1, No. 6(January 8, 1919).

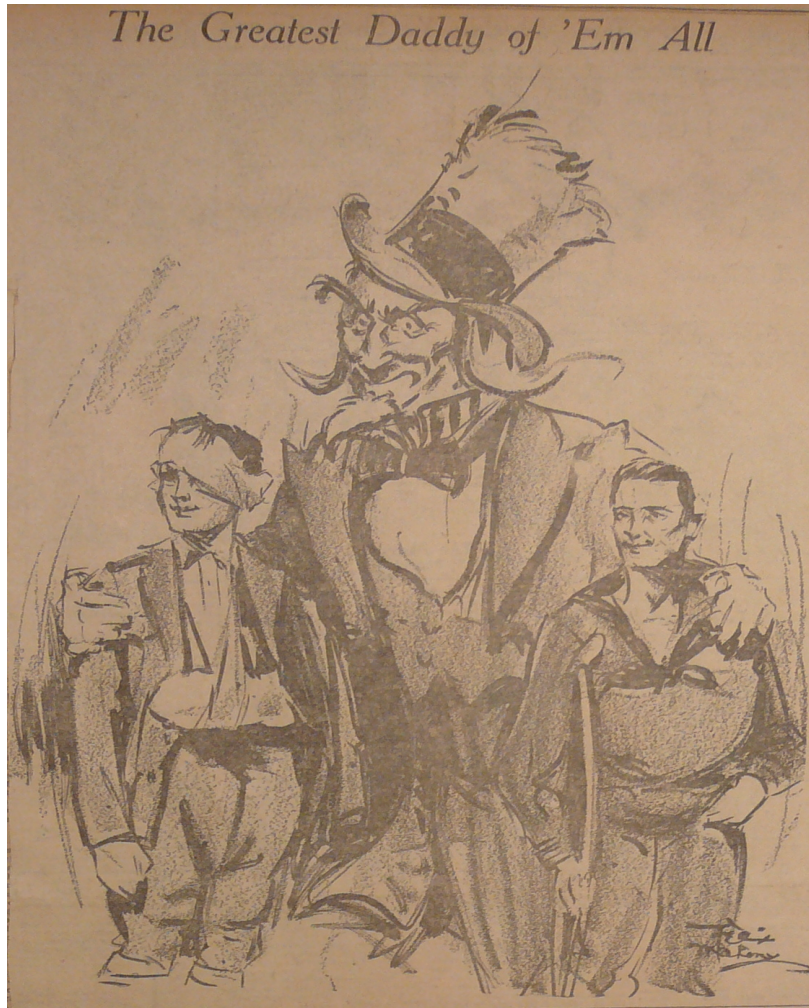
follow... a stupendous task has thrust itself forward in the shape of the care of World War veterans.” To deal with this “task,” a “mammoth machine” had been created, *The Come-Back* reported, which had four main parts. The first was the military hospital itself. Once a soldier was discharged from the service and that facility, he could utilize the second part of the “machine,” and receive disability payments from the Bureau of War Risk Insurance. If the veteran required further medical care, he experienced the third part of the machine: the Bureau of War Risk Insurance would cover the cost of his medical care at a Public Health Service Hospital or, if geographical or hospital space constraints existed, at a civilian hospital. Finally, veterans who were well enough to work, but not well enough to return to their previous occupations were free to take advantage of vocational education programs vis-à-vis the Federal Board for Vocational Education.<sup>92</sup>

In December 1919, *The Come-Back* reminded readers of their right to receive free care in military, civilian, and Public Health Service hospitals, calling such access a “privilege” of which few were aware. In the article, Lieutenant Mathew C. Smith of the Army General Staff noted that discharged servicemen who felt their illness was due to wounds or other disabilities received or aggravated while in the service should arrange a physical exam with the nearest army hospital or representative of the United States Public Health Service. They were advised to bring their discharge papers showing that their disability existed at the time of separation from the military. “However, if these papers are not available,” Smith noted reassuringly, “the man should not hesitate to apply. Such an applicant will be immediately placed under treatment pending the receipt of the necessary papers.”<sup>93</sup>

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<sup>92</sup> "Summary of Provisions Made for Disabled Men," *The Come-Back* May 8, 1920.

<sup>93</sup> "Free Treatment Available for Ex-Servicemen," *The Come-Back* December 24, 1919.



The Come-Back, February 5, 1919<sup>94</sup>

But the newspaper's declaration that the post-war "machine" for disabled veterans was "gaining in the smoothness of its functioning as the days go by," was consistently called into question by patients and veterans' advocates in the halls of Congress, and by the coverage of *The Come-Back* itself. Peppy cartoons regarding prospective benefits were interspersed with articles detailing the intricate process behind accessing those benefits.

Capitalizing on War Risk Insurance, vocational education, and finally, medical care, was more complicated than it may at first have seemed, according to the newspaper. "Soldiers

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<sup>94</sup> "The Greatest Daddy of 'Em All," *The Come-Back* Col. 1, No. 10(February 5, 1919).

desiring direct information on government matters are cautioned to be careful to obtain the proper addresses in order to save time and trouble,” announced one headline in March 1919. The article went on to list a plethora of offices where soldiers could write for information about insurance (the Bureau of War Risk Insurance); back pay and personal effects (the auditor of the War Department); liberty bonds (the officer in charge of liberty bonds at the Quartermaster General’s Office). A slew of separate contact addresses existed for queries from troops of the Navy, Coast Guard, and Marines who were patients at the hospital.<sup>95</sup> Not only was it complicated to file a claim, but it was also not guaranteed that the effort would be fruitful. A question and answer article about compensation under the War Risk Insurance Act was candid. If an ex-soldier obtained a job, it acknowledged, his disability compensation would be “reduced or discontinued.” “Obviously,” the newspaper noted, “this is not just. A man with a disease like tuberculosis or Bright’s disease might by reason of his necessities be forced to find a job and earn something even in spite of the advice of his doctors.” In such a case, according to *The Come-Back*, “the result would be that the more he earned, the less he would get from the government and the government would profit by that man’s industry, even though that man’s industry might be one form of committing suicide.” However, the article pointed out, “such a method of determining the comparison... does not take into consideration that most men who had been in the service for any length of time had gained immeasurably by the experience, and probably had improved their earning capacity.”<sup>96</sup> Disabled men might have lost their full physical or mental health, *The Come-Back* conceded, but they gained the invaluable experience of service. It was, the paper indelicately implied, a wash.

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<sup>95</sup> "Grab Off Right Dope; You'll Find It Here," *The Come-Back* March 19, 1919.

<sup>96</sup> "Compensation under War Risk Act," *The Come-Back* December 31, 1919.

In its coverage of War Risk Insurance benefits and vocational education, *The Come-Back* sent mixed messages: it consistently painted a positive picture of allotments and opportunities, but at the same time, acknowledged with increasing frequency that there were limits to and rules about who could access them. Boastful claims that “the United States government intends to put every disabled soldier and sailor into a good job” gave way to warnings that veterans “gotta be real to pass muster.”<sup>97</sup> Requests for government-funded college courses from men “with trivial hurts,” such as an injured index finger, *The Come-Back* reported in May 1919, would be turned down by a Federal Board for Vocational Education that was scrutinizing cases ever more closely.<sup>98</sup> Straying from its unqualified celebration of government generosity, the newspaper reminded readers that not everyone was “entitled” to all services.

By mid-1920, *The Come-Back* was reporting that veterans’ medical care was on shaky ground, and in need of re-fortification with Congressional funds. In July of that year, the newspaper noted that \$46 million had been appropriated for the establishment of hospitals for discharged men. Among other things, the funding would cover three national sanatoria and two hospitals especially for ex-soldiers with tuberculosis.<sup>99</sup> By late 1920, however, the newspaper reported that the hospitals had yet to be built. “This situation is manifestly unsatisfactory to the disabled ex-service men and women and to the government alike,” R.G. Cholmeley-Jones, Director of the Bureau of War Risk Insurance, was quoted as saying. “It is obvious that it is impracticable for the proper supervision to be given by the government in the treatment of the

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<sup>97</sup> The first quote is from “U.S. Will Put Disabled Men in Good Jobs,” *The Come-Back* December 4, 1918. The second is from “Gotta Be Real to Pass Muster,” *The Come-Back* May 21, 1919.

<sup>98</sup> “U.S. Will Put Disabled Men in Good Jobs.”; “Gotta Be Real to Pass Muster.”

<sup>99</sup> “Hospitals to Be Established for Discharged Men,” *The Come-Back* July 31, 1920. The appropriation will be discussed in more detail in Chapter Four of this dissertation.

disabled if they are scattered in a large number of hospitals,” he added. “It is necessary in the best interests of the patients that they be assembled in larger groups in hospitals which are maintained exclusively for the treatment of ex-service men and women.”<sup>100</sup>

The newspaper’s coverage of post-discharge medical care reflected the larger reality that policies were in constant flux; it thus helped create political awareness among soldier-patients. In the Spring of 1919, *Come-Back* readers learned that 2,000 discharged soldiers were accessing War Risk Insurance benefits, but hospital and sanatorium care was thought to be necessary for “a considerable proportion of the 24,300 soldiers, sailors and marines discharged from active military and naval service because of tuberculosis and for approximately 30,000 cases of psychoneurosis, epilepsy and other nervous and mental disorders reported among the military forces up to December 1, 1918.”<sup>101</sup> In late 1920, *The Come-Back* reported that BWRI Director Richard G. Cholmeley-Jones (along with the newspaper editorial staff) supported an American Legion-sponsored bill providing for the consolidation of the activities of the Bureau of War Risk Insurance, the Public Health Service, and the Federal Board for Vocational Education under one bureaucratic agency.<sup>102</sup>

Interspersed with these policy updates, patients found practical news about meetings among officials of the Public Health Service to address “misunderstandings and delays” in the provision of government insurance and hospital treatment for discharged soldiers.<sup>103</sup> They also

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<sup>100</sup> "Peak Attained in War Risk Men under Army Care," *The Come-Back* September 18, 1920.

<sup>101</sup> "Oughta Be Nice to Be Sick Now," *The Come-Back* Vol. 1, No. 18(April 2, 1919). PL 326 will be discussed in more detail in Chapter Four of this dissertation.

<sup>102</sup> See, for example "Consolidation of U.S. Bureaus Plan of Legion's Proposed Bill," *The Come-Back* December 4, 1920. "War Risk Head Favors Merger of U.S. Bureaus," *The Come-Back* December 25, 1920.

<sup>103</sup> "Health Service Chiefs Gather," *The Come-Back* February 12, 1921.



learned about an American Legion report showing that as many as 109,000 soldiers suffering from pulmonary tuberculosis and mental illness had been prematurely discharged from the military “before being properly cured and with no official effort having been made to keep track of them.”<sup>104</sup> The newspaper of one of the premier military hospitals in the United States was openly acknowledging not only an exponentially increasing demand for services, but also the government’s desperate, and often unsuccessful, attempts to keep up.

### Conclusion

On March 5, 1921, two weeks before *The Come-Back* ceased publication, it reported a jarring statistic from Ewing Laporte, Assistant Secretary of the Treasury: the number of ex-soldiers entering civilian hospitals each month was from 1,000-1,500 in excess of those leaving them. Furthermore, Laporte estimated, a bed capacity of 30,000 would have to be maintained for World War I veterans “for many years to come.” In spite of the fact that there were complaints about private institutions being “unfitted for the care of soldiers,” he maintained, the Public Health Service contract system – wherein ex-soldiers were cared for in civilian hospitals and reimbursed by the government – would have to be continued.<sup>105</sup>

Although *Come-Back* editors, like many army and government officials, subscribed to the belief that the “great need is to guard against hospitalization, that is, (ex-service men) reaching a state of mental and physical inactivity where the thought of initiative or action of any sort takes on the aspects of the impossible,”<sup>106</sup> they had to come to terms with the reality that many

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<sup>104</sup> "American Legion Officials to Parley Soon in Washington," *The Come-Back* January 8, 1921.

<sup>105</sup> "Vets Aid Seems Certain Despite Rush," *The Come-Back* March 5, 1921.

<sup>106</sup> "Reviews Rehabilitation Activities at Fox Hills," *The Come-Back* July 17, 1920.



veterans would seek hospital care for an indefinite period. Patients with tuberculosis and neuropsychiatric diseases posed the biggest societal challenge of all: they would need institutional care for years to come. Confronted with the realities of enacted pre-war policies, bureaucrats and army officials were forced to adapt.

In its early years of publication, *The Come-Back* – mirroring government policies – trumpeted the hope that wounded and ill veterans constituted a temporary problem. But the complaints of soldiers like Samuel Ellis, George B. Russo, Arthur L. Chamberlain, John Henry Gose, and Jeremiah J. Hurley hinted at the idea that the government faced long-term political challenges when it came to veterans' medical care. The widely held sentiments that the government owed injured and ill veterans a safety net, and that chronic conditions such as tuberculosis and mental illness had great long-term implications, were powerful forces. Propelled by the experiences of veterans themselves, *The Come-Back* gradually adjusted its consistently rosy coverage, at times even publicly acknowledging shortfalls and limitations of the medical care and benefits available to former troops. The newspaper's changing tone foreshadowed various policy changes to come.

## CHAPTER FOUR

### **“War was hell but the after-war effects were ‘heller’”: An army responsibility becomes a societal obligation (1918-1920)<sup>1</sup>**

Debates over the army’s extent of responsibility for care gradually gave way to congressional acknowledgement that the ailing soldiers of World War I had become a societal responsibility. In December 1918, the Bureau of War Risk Insurance (BWRI), the Treasury Department agency created to administer insurance and disability compensation payments to World War I veterans, estimated that approximately 640,000 men and women would be discharged from all branches of the military with some disability.<sup>2</sup> By June 1920, the Bureau had sponsored examinations for 155,000 of those former service members and judged them entitled to further treatment. Among them were 15,000 “seriously afflicted with mental troubles, 15,000 and more with tubercular troubles, and 81,000 cases of general disability.”<sup>3</sup> Eventually, according to the Bureau, a total of 30,000 government hospital beds would be required to treat long-term cases of nervous and mental disorders, tuberculosis and respiratory diseases, amputations, and a variety of other ailments.<sup>4</sup>

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<sup>1</sup> The quote is from “Minutes of a Conference between the Public Health Service and the Bureau of War Risk Insurance”, April 13, 1920, 290. Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans Bureau, 1917-1923, Record Group 90, Box 11, NC-34, Entry 23, National Archives and Records Administration, College Park, Maryland.

<sup>2</sup> Additional Hospital Facilities for Discharged Soldiers, Sailors, Marines, and Army and Navy Nurses, House Document No. 481, Sixty-Sixth Congress, Second Session, (Washington, D.C.: Government Printing Office, December 8, 1919), 28-37. A.G. Crane, *The Medical Department of the United States Army in the World War; Volume 13, Part One: Physical Reconstruction and Vocational Education*, ed. M.W. Ireland (Washington, D.C.: Government Printing Office, 1927), 249.

<sup>3</sup> Hospital for Bureau of War Risk Insurance, House Report No. 1098, to Accompany H.R. 14315, Sixty-Sixth Congress, Second Session, (Washington, D.C.: Government Printing Office, June 3, 1920).

<sup>4</sup> Additional Hospital Facilities for Discharged Soldiers, Sailors, Marines, and Army and Navy Nurses, House Document No. 481, 28-37. Crane, *The Medical Department of the United States Army in the World War; Volume 13, Part One: Physical Reconstruction and Vocational Education*, 249.

Those daunting figures, presented convincingly by bureaucrats and medical professionals involved in the medical care system, led to the forging of partnerships among various existing government agencies and gave way to an ultimately unsuccessful congressional mandate. According to Public Law 326, the BWRI would receive case files from branches of the military, then pay the Public Health Service (PHS) to administer hospital and out-patient services to former soldiers.<sup>5</sup> The arrangement marked a shift in focus for both organizations. The BWRI, a small bureaucracy focused primarily on administering the insurance offered under the War Risk Insurance Act, was ill-equipped to undertake the project of overseeing a national medical care program. The Public Health Service, too, was somewhat out of its depth; providing hospital care for discharged service members constituted only one part of a widely varied mission that included the international control of disease and implementing sanitary measures across the U.S. The organization's relatively small number of hospitals and limited staff were hardly adequate for the task at hand.

In the year following the Armistice, the Army Surgeon General's office gradually ceded control of medical care for personnel who would likely never return to duty. In June 1919, it discontinued its Division of Physical Rehabilitation and Special Hospitals. By the end of the next month, the army had passed on to the PHS 14 hospitals containing more than 13,000 beds. In early November 1919, army policies were modified so that all patients would be discharged after spending one year in a military hospital. Some – depending on their medical needs and geographic locations – would be placed under the auspices of the BWRI in PHS hospitals, private facilities under contract with the PHS (“contract institutions”), or Soldiers' Homes. In

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<sup>5</sup> An Act to Authorize the Secretary of the Treasury to Provide Hospital and Sanatorium Facilities for Discharged Sick and Disabled Soldiers, Sailors, and Marines, Public Law 326, H.R. 13026, 40 Stat., 1302, Sixty-Fifth Congress, Third Session, (Washington, D.C.: Government Printing Office, March 3, 1919). For a helpful summary of the law, see: "Hospital Care for Discharged Soldiers," *Modern Hospital Magazine* Vol. XII, No. 4 (April 1919).

other cases, patients would simply be discharged from the military and become BWRI patients, but remain in army hospitals – their status would change from soldier to veteran, and the BWRI, (not the army), would fund their hospitalization.<sup>6</sup> As the BWRI gradually took more patients under its purview, the army oversaw fewer and fewer cases: in just a three month period, for example – between June 1919 and September 1919 – the number of patients being treated in army general hospitals like Washington, D.C.’s Walter Reed decreased from 30,000 to slightly less than 20,000. By September 1920, there were less than 3,000 patients in an ever-decreasing number of army general hospitals. In approximately the same period – between May 1919 and October 1920 – the number of beds available in army general hospitals decreased from about 40,000 to 3,000.<sup>7</sup>

Under the new arrangement, officials of government agencies struggled to define areas of control and standards of treatment. Army officials expressed trepidation about sending patients to PHS facilities, which they felt could not offer the specialized and efficient treatment available in some military hospitals. For their part, PHS field officers complained that the army unjustifiably denied admission to some patients and enforced inappropriately strict discipline in its institutions. There were conflicts, too, between the BWRI and PHS, regarding control of funding and how veterans should be treated, among other things. The system was unsatisfactory to virtually all concerned, rife with bureaucratic lag and confusion. “It had not been supposed that the soldiers, sailors and marines would be discharged from the service immediately,” a BWRI medical adviser wrote in 1921, “as it was understood to be the intention of the

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<sup>6</sup> Sanders Marble, *Rehabilitating the Wounded: Historical Perspectives on Army Policy*, (Falls Church, VA, July 2008), 21-23.

<sup>7</sup> Frank W. Weed, *Medical Department of the United States Army in the World War; Volume 5: Military Hospitals in the United States*, ed. M.W. Ireland (Washington, D.C.: Government Printing Office, 1923), 54.

government to retain all those suffering from injuries and illnesses incurred in or aggravated by service until the maximum degree of improvement had been obtained.” Much to the chagrin of government bureaucrats, however, “this procedure was not... carried out, and the Bureau of War Risk Insurance was suddenly confronted with the problem of caring for thousands of disabled ex-service men and women who were presenting their claims daily when no general hospitalization program had been mapped out...”<sup>8</sup>

Even as government funding increased for the hospitalization of veterans, problems coordinating the work of various government agencies remained, and helped pave the way for the implementation of longer-term solutions. With everyone – the PHS, the BWRI, the army, Congress – seemingly to blame for shortfalls, no one was fully responsible for fixing them. By 1920, veterans’ advocacy organizations, bureaucrats, and medical professionals increasingly argued that the system was broken. The government’s failure to fulfill promises made to those who served using available resources helped those groups convincingly argue that the ailing soldiers of World War I should be considered more than a temporary problem, and that the extent of their needs justified sweeping policy changes.

### *The Bureau of War Risk Insurance*

The BWRI was established in September 1914 with the passage of the War Risk Insurance Act (WRIA). The original act (and thus, the purview of the agency) was relatively limited; it stipulated that the bureau would oversee insurance policies that would cover

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<sup>8</sup> L.B. Rogers, "The War Risk Act and the Medical Services Created under It," *Journal of the American Medical Association* Volume 26, Number 16(April 16, 1921).

“American vessels, their freight and passage moneys and cargoes against war risks.”<sup>9</sup> As the country mobilized for war, however, policymakers considerably expanded the BWRI’s mandate. 1917 amendments to the WRIA allowed the government to serve as a purveyor of disability and life insurance policies for soldiers, and provide financial assistance to a service member attempting to fulfill his duty of “supporting his family... while absent from home on military duty.”<sup>10</sup> The 1917 version of the WRIA also guaranteed that discharged soldiers who needed medical care could receive it, but it did not stipulate where and how. According to Section 302 of the law, “the injured person shall be furnished by the United States such reasonable governmental medical, surgical, and hospital services and with such supplies, including artificial limbs, trusses, and similar appliances, as the director (of the Bureau of War Risk Insurance) may determine to be useful and reasonably necessary...”<sup>11</sup> But the act contained no further explanation of how such ideals would become reality. Given the BWRI’s mandate to oversee all aspects of the WRIA, it was responsible for taking on the difficult and thankless task of defining how to fulfill an exceedingly vague promise regarding health services.

As more and more soldiers became veterans, the BWRI’s original staff of about 20 employees grew and its duties expanded; by December 1, 1920, the bureau had adjudicated more than 430,000 claims for death and disability compensation and administered \$3.8 billion worth

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<sup>9</sup> An Act to Authorize the Establishment of a Bureau of War Risk Insurance in the Treasury Department, Public Law 193, S. 6357, 38 Stat. 711, Sixty-Third Congress, Second Session, (Washington, D.C.: Government Printing Office, September 2, 1914).

<sup>10</sup> The quote is from Richard G. Cholmeley-Jones, "War Risk Insurance," *Scientific Monthly* Vol. 12, No. 3(March 1921): 228-34. For a detailed explanation of the Act and related secondary sources, see Chapter One.

<sup>11</sup> An Act to Amend an Act Entitled 'an Act to Authorize the Establishment of a Bureau of War Risk Insurance in the Treasury Department,' Approved September Second, Nineteen Hundred and Fourteen, and for Other Purposes, Public Law 90, H.R. 5723, 40 Stat. 398, Sixty-Fifth Congress, First Session, (Washington, D.C.: Government Printing Office, October 6, 1917), 406.

of insurance for approximately 228,000 men and women.<sup>12</sup> But in the closing months of the war, there were plenty of reports of neglect and inefficiencies when it came to the BWRI's handling of the sick and wounded.<sup>13</sup>

The winter of 1918-1919, which saw the declaration of peace and a flood of soldiers out of the military and its hospitals, was a transitional moment for the BWRI. An organization founded primarily to adjudicate financial claims was faced not only with a huge increase in administrative work, but also with the task of arranging for the provision of physical exams and further medical care for ailing former troops. In December 1918, the newly anointed Secretary of the Treasury, Carter Glass, made it one of his first orders of business to appoint a new head of the BWRI, which had recently been attacked by members of Congress for being inefficient and lax in disbursing compensation checks to discharged soldiers. Glass turned to Col. Henry D. Lindsley, a past president of Southwestern Life Insurance Company of Dallas, Texas, and former Chief of the War Risk Insurance Section of the American Expeditionary Forces.<sup>14</sup> Lindsley aimed first and foremost to restore faith in the BWRI. He urged Congress not to proceed with a planned investigation of the organization and requested that, "a reasonable chance be given to him to satisfy Congress."<sup>15</sup> In March 1919, when a recently dismissed bureau employee charged the organization with "gross inefficiency and wastefulness," Lindsley shot back that the claims were "tissues of falsehoods."<sup>16</sup> In effect, both BWRI leadership and congressional

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<sup>12</sup> Cholmeley-Jones, "War Risk Insurance," 228-34.

<sup>13</sup> See, for example: "Sick and Wounded of American Army Fail to Get Pay," *The Atlanta Journal-Constitution* December 14, 1918. "Disabled Soldiers from Connecticut Are Left by the Government to Shift for Themselves," *The Hartford Courant* January 12, 1919.

<sup>14</sup> "Glass Takes Oath as Treasury Head," *The New York Times* December 17, 1918.

<sup>15</sup> "War Risk Bureau Inquiry Is Halted," *The New York Times* January 11, 1919.

<sup>16</sup> "Defends War Risk Bureau," *The New York Times* March 21, 1919.

representatives were struggling to prove to veterans that their insurance and compensation payments would be distributed in good faith, that pre-war policy promises were not empty, and that trust in government should not be questioned.

Within just five months of his appointment as Director of the Bureau of War Risk Insurance, however, Lindsley made a drastic turnabout, declaring that the organization he oversaw was “on the verge of breakdown and failure.” Lindsley charged that the Treasury Department limited the effectiveness of the BWRI by communicating in a “negative and destructive” manner and constantly “suggesting reasons why things cannot be done.” For example, Lindsley alleged that his authority to hire his own staff had repeatedly been called into question by a Treasury Department that scrutinized and questioned each appointment and salary request. Secretary of the Treasury Glass duly responded to Lindsley’s accusations. Glass accused the Bureau head of “insufferable personal vanity” and argued that there were no considerable delays or bureaucratic red tape at the BWRI. Only three out of 9,201 requested appointees had been reviewed by the Treasury Department, he noted, and only because the salaries requested for them were inordinately high. In May 1919, after spending approximately six months at the helm of the BWRI, Lindsley left the agency to join the leadership of a newly powerful veterans’ organization, the American Legion.<sup>17</sup>

Lindsley was replaced at the bureau by Richard Gilder Cholmeley-Jones, who had served as a Colonel in the War Risk Insurance section in France.<sup>18</sup> Prior to the war, Cholmeley-Jones worked in New York’s burgeoning insurance industry for the Mutual Life Insurance Company then independently as a broker. As head of the BWRI, he was not only credited with re-

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<sup>17</sup> "War Risk Chief out after Break," *The New York Times* May 19, 1919.

<sup>18</sup> "Cholmeley-Jones in War Risk Bureau," *The New York Times* May 29, 1919.



organizing the administration of payments of claims, but was also widely viewed as a great advocate for disabled and ill veterans. Cholmeley-Jones served as Director of the embattled bureau for two tumultuous years, from May 1919 through March 1921. When he died of heart disease at age 38 in February 1922, his friends alleged that, “his illness was superinduced (*sic*) by the hard work he performed in connection with the war.” In contrast with the conditions surrounding Lindsley’s stormy departure, *The New York Times* reported that when Cholmeley-Jones left the BWRI, “he left most of the pending cases cleared up and every bit of the official machinery working in co-ordination.” Upon his death, he was cited by the American Legion as the “staunchest supporter in the fight for justice to disabled men.” During two years under Cholmeley-Jones’ directorship, the BWRI arranged and paid for hospitalization for 79,000 ex-service men and women.<sup>19</sup>

In spite of accolades for its director and large numbers treated, the BWRI faced significant challenges between 1919 and 1921. Cholmeley-Jones himself often frankly acknowledged shortfalls not only within his own organization, but also in its collaboration with the Public Health Service. The latter agency, from the start, was somewhat unprepared to take on the task of providing medical care to thousands of ill and injured troops.

### *The Public Health Service*

The Marine Hospital Service, the forebear to the PHS, was established in 1798 with the mission of providing relief to sick and injured seamen, but its duties became increasingly varied during the nineteenth and early twentieth centuries. According to an Act “for the relief of sick and disabled seamen,” a portion of sailors’ monthly pay was to be deducted in order to fund a

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<sup>19</sup> "R. Cholmeley-Jones Dies in Hospital," *The New York Times* February 22, 1922.

system of hospitals and dispensaries at or near ports, so that they could seek care, even if they were traveling far from home. Harry S. Mustard points out that the act did not become law without controversy and opposition. Some legislators said the payroll deduction was a tax and called it unconstitutional. Others argued that the health and safety of sailors was a matter best left to the states. But in the end, the act passed “not as a progressive move that would give merchant seamen something better than average citizen,” but in order to ensure they had some guaranteed access to medical care. Because such services were locally based (and, generally, locally accessed) in the late eighteenth century, the law was seen as a means of providing seamen the opportunity to seek medical care even if they were away from home. Former Secretary of the Treasury Alexander Hamilton saw both humanitarian and commercial benefits to the legislation. It would, he said, “protect from want and misery a very useful, and for the most part, a very needy Class of the Community,” and serve “navigation and trade” interests.<sup>20</sup>

Throughout the nineteenth century, the initial priority of maintaining state, as opposed to federal, control of marine hospitals and personnel was increasingly called into question. It was unacceptable to have different standards of care and practice at institutions throughout the country, and legislators were increasingly wary of a lack of centralized control in the organization, which they felt fostered a political spoils system for hospital building as opposed to a rational and pragmatic one. As trade increased, more policymakers came to believe that one overarching entity, as opposed to individual states, should be responsible for the interpretation and enforcement of international and interstate quarantine laws. There was a general “trend toward nationalizing health activities,” and the Marine Hospital Service gained more

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<sup>20</sup> All quotes are from Harry S. Mustard, *Government in Public Health* (New York, New York: The Commonwealth Fund, 1945), 25-67. The Hamilton quotes are on p. 32.

responsibility. In 1912, the agency's expanded mission was made somewhat more official when it was re-named the United States Public Health Service.<sup>21</sup>

When President Woodrow Wilson passed an executive order on April 3, 1917 making the United States Public Health Service part of the military forces of the United States, operating hospitals was just one function of the burgeoning organization. In 1917, the PHS treated about 18,000 patients in its 19 marine hospitals.<sup>22</sup> It also devoted vast resources to scientific research, the prevention of the spread of epidemic diseases, and the monitoring of state quarantine and immigrant inspection stations. The April 1917 executive order meant that “all peacetime activities – investigations of the pollution of the Ohio River, the scientific studies of the laboratories, the rural health demonstrations, programs against trachoma and hookworm disease – had to become a dim background to the more pressing problems of war.” High-ranking officials of the PHS were assigned to duty with – essentially, put on loan to – the Army, Navy, and Coast Guard.<sup>23</sup>

In the short-term, as troops arrived at their U.S. posts from their hometowns and cities, the PHS undertook an expansive program of improving sanitation measures in communities surrounding military camps and bases. As then PHS Surgeon General Rupert Blue put it, “if the soldier and the sailor are to be kept well, the civilian with whom they come in contact must not be permitted to have a communicable disease, and the civil environment which the fighting man

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<sup>21</sup> All quotes are from Ibid., 25-67. Also see Bess Furman, *A Profile of the United States Public Health Service, 1798-1948* (Washington, D.C.: National Institutes of Health, 1973).

<sup>22</sup> Annual Report of the Surgeon General of the Public Health Service of the United States for the Fiscal Year 1917, (Washington, D.C.: Government Printing Office, 1917), 309.

<sup>23</sup> Furman, *A Profile of the United States Public Health Service, 1798-1948*, 314.

enters must be kept in a clean and wholesome condition.”<sup>24</sup> To these ends, the PHS attempted to improve the health of the local populations surrounding cantonment zones in mainly rural areas such as Petersburg, Virginia, Columbia, South Carolina, and Fort Riley, Kansas, among others. There, PHS officers inspected sewer systems, instituted vaccination campaigns for both children and adults, and attempted to ensure a clean water supply and hygienic conditions in local restaurants. According to Blue, the benefits of the PHS efforts went beyond those immediately visible in a few isolated communities. The wartime emergency, he said, was “building permanently for a better public health,” and “laying the foundations for an improvement in community conditions which we have every reason to believe will gradually spread throughout the United States.”<sup>25</sup>

Within just a few months, though, the responsibilities of the PHS extended beyond sanitation and the health of the civilian population. As soldiers were discharged with illnesses and disabilities, the organization was called upon to use its limited staff and resources to treat former service members. As then Bureau of War Risk Insurance Director, William C. Delanoy said in July 1918, “the only ‘governmental’ hospital services available for this work are the hospitals and relief stations of the United States Public Health Service.” Army and navy hospitals, he pointed out, could not lawfully be used for the care of civilians. In any case, he said, they were entirely occupied with soldiers and officers.<sup>26</sup>

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<sup>24</sup> Rupert Blue, "Conserving the Nation's Man Power," *The National Geographic Magazine* Vol. 32, No. 3(September 1917): 255.

<sup>25</sup> *Ibid.*: 278.

<sup>26</sup> "Letter from William C. Delanoy to the Secretary of the Treasury", July 30, 1918. Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans' Bureau, 1917-1923, Record Group 90, Box 7, NC-34, Entry 23, National Archives and Records Administration, College Park, Maryland.

In September 1918, Rupert Blue made it clear that his organization was somewhat overwhelmed by its new obligations. When the PHS assumed responsibility for providing care for discharged soldiers, there were 1,500 in-patients in 20 marine hospitals across the country.<sup>27</sup> By mid-1918, 14,000 service members had been discharged from the army for tuberculosis alone; the government expected another 20,000 to be discharged for the disease during the remainder of 1918 and throughout 1919. The PHS, Blue reported, was finding it difficult to handle the load. In order to serve BWRI patients, it had filled many of its hospitals “to overflowing, by placing beds in hallways, on verandas, and even in tents scattered about the reservations...” Furthermore, it had rented private dwellings and converted them to temporary hospitals, a practice that was “neither satisfactory nor economical.”<sup>28</sup> Blue and others argued that instead of strapping the limited facilities of the PHS, special arrangements should be made for Bureau of War Risk Insurance patients. “Hospital accommodations,” the 1918 PHS annual report said, “should be supplied for the treatment of discharged soldiers and seamen.”<sup>29</sup>

*Congressionally-sanctioned collaboration: Relationships and responsibilities “not clearly defined”*

In the fall and winter of 1918 and 1919, representatives of the army, Bureau of War Risk Insurance, and Public Health Service partook in a series of congressional hearings. They

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<sup>27</sup> Hugh S. Cumming, "The Work of the Public Health Service in the Care of Disabled Veterans of the World War," *The Military Surgeon* Vol. XLIX, Number 1(July 1921): 1898. The number of hospitals available was reported in Annual Report of the Surgeon General of the Public Health Service of the United States for the Fiscal Year 1918, (Washington, D.C.: Government Printing Office, 1918).

<sup>28</sup> "Letter from Surgeon General Rupert Blue to Secretary of the Treasury", September 17, 1918. Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans' Bureau, 1917-1923, Record Group 90, Box 7, NC-34, Entry 23, National Archives and Records Administration, College Park, Maryland.

<sup>29</sup> Annual Report of the Surgeon General of the Public Health Service of the United States for the Fiscal Year 1918, 318.

discussed and debated the scope of the problem at hand, the availability of facilities and personnel, and the coordination of governmental efforts. This series of debates marked the first federal-level acknowledgement that government-sponsored veterans' hospitals might constitute a long-term political reality. In December 1918, the Committee on Public Grounds heard testimony about whether or not a tuberculosis sanitarium for veterans should be built in Dawson Springs, Kentucky. Eventually, it approved the appropriation of funding for a Kentucky veterans' hospital, setting a precedent that such an institution could be located and structured on the basis of congressional representatives' political savvy, and begging the question of whether a federal hospital system for ex-service members would be established piecemeal.<sup>30</sup> A few months later, the same committee held hearings regarding the extent of power of the PHS and the question of whether that organization, in its quest for resources, would take over supposedly under-utilized, or soon to be abandoned military hospitals. Following the debates, Congress passed Public Law 326, which allocated millions of dollars in funding to the Secretary of the Treasury and signified that the government would attempt to make good on its promise—albeit within a somewhat harried federal bureaucracy—to provide medical care to ex-service members who needed it. An examination of these two hearings reveals that during the months surrounding the Armistice, the U.S. government was struggling to come up with a viable solution for dealing with the health fallout of war, and that no set policy was yet in place for doing so; Congress was still torn regarding the question of how funding for veterans' medical services should be proposed and allotted. As late as May 1919—two months after the passage of PL 326 and six

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<sup>30</sup> Rosemary Stevens argues that “the political rifts” brought about by the Dawson Springs hearings had long-term policy implications: they “suggested that the only fair way to design a national hospital program for veterans was to remove it from the political process altogether,” and put it in the realm of “experts, who were to be drawn from the national organizations of health and medicine.” Rosemary A. Stevens, “Can the Government Govern? Lessons from the Formation of the Veterans Administration,” *Journal of Health Politics, Policy and Law* Vol. 16, no. No. 2 (1991): 291.

months after the Armistice – the main organizations responsible for providing medical care for ex-soldiers were operating without a workable means by which to coordinate their respective and joint activities.

On September 18, 1918, a few days after U.S. and French troops declared a decisive victory in the Battle of St. Mihiel, Democratic representative David H. Kincheloe tried to convince his colleagues to approve funding for a veterans' hospital in Dawson Springs, a wooded town in his Eastern Kentucky district. Kincheloe had approached officials of the Bureau of War Risk Insurance and the Public Health Service about such a plan in the preceding months, he said, "knowing that there was some talk of this kind of an institution." Dawson Springs, he pointed out, was on the main line of the Illinois Central Railroad route between Louisville and Memphis; it was centrally located among the larger part of the U.S. population; and, perhaps most importantly, a group of the town's business people had come together and obtained 10,000 acres of land, the title of which they were willing to pass on to the U.S. government at no cost.<sup>31</sup>

The ensuing debate about Dawson Springs highlighted a central issue of post-war debates about veterans' health care; in the fall of 1918, government and medical officials were first coming to the difficult realizations that the pre-war hope of healing soldiers' wounds and ailments before discharge from the army was unrealistic, and that the promises contained in the War Risk Insurance Act made all sick and injured former soldiers a societal, not just a military responsibility. When the Chief Medical Advisor of the Bureau of War Risk Insurance seconded Kincheloe's sentiments regarding the necessity of a veterans' hospital in Kentucky, Frank Clark (D—FL), who chaired the Committee on Public Buildings and Grounds, wondered why the army

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<sup>31</sup> Hearings before the Committee on Public Buildings and Grounds, House of Representatives, on H.R. 12917, Providing for the Establishment of Sanitoriums for the Treatment of Persons Discharged from the Military and Naval Forces of the United States, H.R. 8828, H.R. 12881, Sixty-Fifth Congress, First Session, (Washington, D.C.: Government Printing Office, September 18, 1918), 3-4.

was not completing all necessary medical work. “If they are entirely cured there would be no necessity for discharging them, and they might go back in the service,” he noted, echoing the hopes of those who debated pre-war health policy in 1917. But by September 1918, bureaucrats working within the system had a new grasp on reality. “I do not imagine in time of war it is the business of the Army Medical Corps to try to make healthy civilians, but rather to take care of the wounded and injured during active fighting,” Charles E. Banks, Chief Medical Advisor of the BWRI said. Once the “time of war” had ceased, he said, it would remain difficult to pursue the pre-war policy of treating soldiers within the military health system; all personnel – from conscripted privates to medical officers – were eager for discharge. Plus, it was difficult to justify funding a vast army medical system in peacetime.<sup>32</sup>

The Dawson Springs discussions also made it clear that government representatives were beginning to realize and acknowledge that large numbers of former soldiers needed to be treated for chronic conditions such as tuberculosis, rather than heroic battlefield injuries.<sup>33</sup> Echoing the sentiments of a BWRI official, who called tuberculosis “the great problem” among discharged soldiers and sailors, Banks pointed out that almost one-quarter of those discharged from the army and navy were suffering from the disease.<sup>34</sup> He noted that 14,000 had already been discharged with TB, and another 34,000 were predicted to be released with the disease in 1919; 75 percent of those former soldiers were expected to seek treatment in sanitarium. The demand for care, Banks argued, far surpassed the BWRI’s supply of 1,400 beds suited to such patients. The

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<sup>32</sup> Ibid., 7.

<sup>33</sup> The realization mirrored a similar trend in larger society: at the beginning of the twentieth century, chronic illnesses overtook acute conditions as the primary health threat affecting Americans. *Dying for Work: Workers' Safety and Health in Twentieth-Century America* ed. David Rosner and Gerald Markowitz (Bloomington: Indiana University Press, 1989), See especially the introduction.

<sup>34</sup> “Letter from William C. Delanoy to the Secretary of the Treasury,” July 30, 1918. “Letter from William C. Delanoy to the Secretary of the Treasury”.



organization would need access to 13,000 beds in order to adequately serve veterans with tuberculosis, Banks said. He argued that providing treatment was necessary not simply based on the premise that the government had an obligation to veterans, but because tuberculosis constituted “a great public health and economic problem.” “Men who have broken down... in a diseased condition,” he said, “are a menace to their families and the communities where they reside.”<sup>35</sup> The high prevalence of tuberculosis, in fact, helped bureaucrats and policymakers justify permanent veterans’ hospitals in places like Dawson Springs. “In tuberculosis, there is a very frequent recurrence of the breakdown, and these men will not only come in now, but they will come in later on and keep coming in from time to time as they break down,” Banks said.

But some legislators resisted the idea of providing free medical care for a lung disease contracted by ex-servicemen, many of whom had never been shipped abroad, much less seen battle. They were conflicted about the extent of governmental obligations to such individuals. Frank Clark wondered aloud during the Dawson Springs debates how many veterans with tuberculosis had entered the service with the disease, and whether the same “allowances” were made for them as for those who had contracted it as soldiers. No one was knowingly accepted to serve who had tuberculosis, Banks reported, though he did concede that draft exams were often “superficial.” Some may indeed have had the disease before entering the military, but some otherwise latent cases may have broken down under the strain of service. Clark remained skeptical, taking a broad view of the issue at hand: “What do you think of the idea that when a man is discharged from the service he should be sent to an institution of this sort,” he asked Banks. The BWRI medical advisor approached the question pragmatically. It was a “good

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<sup>35</sup> Hearings before the Committee on Public Buildings and Grounds, House of Representatives, on H.R. 12917, Providing for the Establishment of Sanitoriums for the Treatment of Persons Discharged from the Military and Naval Forces of the United States, H.R. 8828, H.R. 12881, 5.

business proposition” to treat them and get them well,” Banks argued.<sup>36</sup> Clark’s and Banks’ perspectives provided an early hint of two opposing sides of the debate regarding veterans’ care: some argued that free medical care fostered dependency, while others argued that dependency could be staved off with proper treatment.

During debates about whether or not an institution should be opened at Dawson Springs, an important precedent was set as a cohort of BWRI and PHS experts made the case that fiscal concerns – for example, the idea that large, centrally located hospitals were cheaper and more efficient than smaller, widely disbursed ones – could not justifiably trump humanitarian questions, such as whether or not a sick veteran could access a facility in proximity to his home and family. In response to representatives’ queries regarding the practicality of opening a 500-bed hospital at Dawson Springs, as opposed to one that might hold 1,000 or more patients, the Public Health Service’s Director of Engineering remarked that larger hospitals were “more economical,” but did not afford the opportunity for families of patients to visit. It was not ideal, for example, to send a man from Maine to Kentucky for treatment.<sup>37</sup> The principle that veterans – even those who had not seen battle – deserved access to institutions close to their homes and families continued to hold throughout the early 1920s and shaped the veterans’ hospital system that eventually emerged.

The hospital at Dawson Springs was only one small part of the broad system of veterans’ care that representatives of the PHS and BWRI envisioned. A couple of months after

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<sup>36</sup> Ibid., 6-7. For a thorough analysis of the army’s handling of tuberculosis during World War I, and the great challenges posed by the disease, see Carol R. Byerly, *Good Tuberculosis Men: The Army Medical Department's Struggle with Tuberculosis* (Washington, D.C.: Borden Institute, Forthcoming).

<sup>37</sup> Hearings before the Committee on Public Buildings and Grounds, House of Representatives, on H.R. 12917, Providing for the Establishment of Sanitoriums for the Treatment of Persons Discharged from the Military and Naval Forces of the United States, H.R. 8828, H.R. 12881, 12.

Representative Kincheloe and others first made the case for building a hospital in Kentucky, Clark and his colleagues on the Committee on Public Grounds continued to hear testimony from representatives of the army, BWRI, and PHS regarding the general topics of how much funding and how many facilities were necessary to adequately provide for the medical care of veterans. During these debates, it became clear that, even though the army was discharging soldiers rapidly, and would not maintain control of health care for veterans, it would pass on only limited resources to the BWRI and PHS.

Winford H. Smith, of the Army Surgeon General's Hospital Division, pointed out in December 1918 that the army still expected 50,000 sick and disabled soldiers to be returned to domestic military hospitals from abroad, and could therefore spare little in the way of facilities for the use of the PHS.<sup>38</sup> Smith's determination to conserve resources turned out to be well founded; peak patient load in army hospitals was not reached until May of 1919.<sup>39</sup> In order to ensure that the army could fulfill pre-war governmental mandates to care for soldiers until "maximum curative results" were achieved, Smith felt he had to hold tight to facilities.<sup>40</sup> Still, at the behest of congressional representatives who were frustrated with the army's hoarding of resources after peace had been declared, Smith eventually suggested that the PHS could take over a 700-bed army hospital at Hot springs, North Carolina and a general hospital at Corpus

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<sup>38</sup> Hearings before the Committee on Public Buildings and Grounds, House of Representatives, on H.R. 13026, a Bill to Authorize the Secretary of the Treasury to Provide Hospital and Sanatorium Facilities for Discharged Sick and Disabled Soldiers and Sailors, Sixty-Fifth Congress, Second Session, (Washington, D.C.: Government Printing Office, December 9, 1918), 13.

<sup>39</sup> Weed, *Medical Department of the United States Army in the World War; Volume 5: Military Hospitals in the United States*, 54.

<sup>40</sup> The quote is from "Council of National Defense General Medical Board Meeting Minutes, September 9, 1917", 5. Council of National Defense, Record Group 62, Box 426, General Medical Board, Secretary's Office, National Archives and Records Administration, College Park, Maryland.

Christi, Texas. But he unapologetically qualified the seeming altruism by declaring that the facilities were “two of the least desirable properties which we now occupy.”<sup>41</sup>

The PHS, in fact, was resistant to the idea of relying on old army institutions, let alone the least desirable ones. William G. Stimpson, who oversaw the selection of hospital sites for the Public Health Service, echoed the sentiments of those who had testified regarding the necessity of a hospital at Dawson Springs. Bureau of War Risk Insurance patients would have to be treated for chronic diseases “for a great many years,” he argued. The army’s institutions, many of which were not fireproof and did not have heat or running water throughout, were simply insufficient for the task at hand. Plus, he argued, some of the hospitals were located on larger army cantonments, which, once abandoned after the war, would feel like “nothing more or less than deserted villages” and have a “depressing effect” on patients. Stimpson requested that Congress appropriate \$10 million for the Public Health Service to add 5,000 beds to the organization’s existing hospitals. Excess BWRI patients, he suggested, could be cared for in army hospitals as they gradually became available throughout demobilization.<sup>42</sup>

The PHS obtained the requested funding on March 3, 1919 with the passage of Public Law 326, which bolstered the precedent that the federal government would continue to attempt to fulfill its promise of overseeing comprehensive medical care for veterans. The landmark law appropriated \$3 million for the takeover of a newly built army hospital in Chicago, \$1.5 million to establish a tuberculosis sanitarium at Dawson Springs, Kentucky, \$2 million for enlarging a

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<sup>41</sup> Hearings before the Committee on Public Buildings and Grounds, House of Representatives, on H.R. 13026, a Bill to Authorize the Secretary of the Treasury to Provide Hospital and Sanatorium Facilities for Discharged Sick and Disabled Soldiers and Sailors, 22.

<sup>42</sup> Hearings before the Committee on Public Buildings and Grounds, House of Representatives, on a Proposal for the Relief for Contractors Engaged on Public Building Construction under the Supervision of the Treasury Department, H.R. 13026, a Bill to Authorize the Secretary of the Treasury to Provide Hospital and Sanatorium Facilities for Discharged Sick and Disabled Soldiers and Sailors, Sixty-Fifth Congress, Second Session, (Washington, D.C.: Government Printing Office, December 3 and 6, 1918), 16-17.

PHS hospital in Stapleton, New York, and \$1.4 million for the construction of hospitals for the use of BWRI patients in Washington DC and Norfolk, Virginia. It set aside another \$1.5 million for an emergency fund that the Secretary of the Treasury could use to purchase additional land and buildings, and \$785,000 for the PHS to use for hospital operations during the remainder of 1919. In spite of concerns expressed by Stimpson regarding the “depressing effect” of using army cantonments for the treatment of BWRI patients, the bill also appropriated \$750,000 in order to remodel and adapt seven army camp hospitals located across the country, which would be transferred to the PHS.<sup>43</sup>

Public sentiment regarding the law was generally positive; newspaper articles presented it as a justified fulfillment of an obligation to former service members.<sup>44</sup> But there was also some staunch opposition to its passage. In January 1919, a bipartisan group of representatives argued that the war was over, and the need for medical care less dire than it once was. In response to earlier claims by BWRI and PHS officials that illnesses like psychoneurosis and tuberculosis required long-term care, the representatives pointed out that the average hospital stay for a tuberculosis patient was just six months. Furthermore, they continued the trend of questioning the worthiness of BWRI patients, some of whom they said had been in the army no more than a few weeks. Just as many of these men had received medical care in local institutions before the war, the representatives said, they could “be cared for better, more promptly, and more

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<sup>43</sup> An Act to Authorize the Secretary of the Treasury to Provide Hospital and Sanatorium Facilities for Discharged Sick and Disabled Soldiers, Sailors, and Marines, Public Law 326, H.R. 13026, 40 Stat., 1302. Also see “New Tuberculosis Sanatorium Dedicated,” *Journal of the American Medical Association* Vol. 78 No. 8(1922). When Dawson Springs finally opened in 1922, it was placed under the auspices of the Veterans’ Bureau, which had begun overseeing care for ex-service members. The total cost to the government for the institution was \$2.3 million.

<sup>44</sup> “Huge Plan to Care for the Disabled,” *Boston Daily Globe* April 6, 1919. “Disabled Soldiers to Get U.S. Care in Big Hospitals,” *Chicago Daily Tribune* April 6, 1919, 6. “Chain of Hospitals for Disabled Men,” *The New York Times* April 6, 1919. “Uncle Sam Ready to Care for Men Disabled in War,” *New York Tribune* April 13, 1919.

economically in civilian institutions now in existence than in any other way.”<sup>45</sup> In effect, the minority report was a statement against pre-war legislation guaranteeing that discharged soldiers would have access to publicly sponsored medical care. Although its rationale seemed ideologically sound to many, it did little to release the government from its legal obligations.

As their patient load increased, the BWRI and PHS attempted to hash out the dynamics of their working partnership. In January 1919, Charles E. Banks, Chief Medical Advisor of the BWRI drafted a memo to the director of his organization, suggesting some rough guidelines for how to coordinate activities with the PHS. In providing hospital care for veterans, it would be necessary to temporarily lease facilities, he said. Representatives of the BWRI should be responsible for choosing the facilities, which would be limited to use exclusively by BWRI patients. The PHS would administer care there – just as they would at official PHS hospitals – with their own personnel. Any physicians, nurses, and attendants working with BWRI patients would be authorized and paid for by the Bureau, which would determine compensation rates. Furthermore, Banks suggested, the BWRI would pay for hospital operations and equipment at cost. The PHS would be obligated to submit the estimated costs of each leased hospital for the following month, which would not be considered valid until the institutions were approved by the BWRI. If the PHS required clerical help in order to execute such plans, its representatives could request it and the BWRI would pay for it, provided the request was approved.<sup>46</sup> Banks’

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<sup>45</sup> Hospital and Sanatorium Facilities for Discharged Sick and Disabled Soldiers and Sailors, Report No. 879, to Accompany H.R. 13026, Sixty-Fifth Congress, Third Session, (Washington, D.C.: Government Printing Office, December 21, 1918), 5. The report was signed by Aaron S. Kreider (R-Pennsylvania), Richard Nash Elliott (R-Indiana); Henry A. Barnhart (D-Indiana); and Joseph Jefferson Mansfield (D-Colorado).

<sup>46</sup> "Memorandum from B.W.R.I. Chief Medical Advisor, to the Director, Bureau of War Risk Insurance, Re. Hospitalization of Patients of the Bureau of War Risk Insurance under the Administration of the United States Public Health Service ", January 23, 1919. Records of the Public Health Service, Correspondence with War Risk

plan gave the BWRI virtually full control of major decisions and little autonomy to PHS personnel.

Although the PHS and BWRI had, in some ways, a seamless partnership – PHS officers comprised some of the staff at the offices of the Medical Section of the BWRI, for example – friction between the two organizations increased over time. PHS representatives resented the heavy-handed managerial tactics of their counterparts at the bureau. For their part, BWRI representatives – since they were charged with the onerous task of ensuring the functionality of a system of care for veterans – had little choice but to impose strict regulations. The problem, then, was not that officials in the BWRI and PHS did not attempt to meet needs and fulfill obligations; it was that the two organizations had a bevy of responsibilities, but limited resources available to fulfill them and coordinate their services.

During the spring and summer of 1919, as the war became more of a distant memory for many Americans, the PHS consistently took on an increasing share of the post-war health burden. In June 1919, the latter organization worked with 24 contract hospitals. By September of the same year, it had signed on with 920. In June 1919, a total of 3,279 BWRI patients were under treatment at PHS hospitals; approximately 1,500 were being treated for neuro-psychiatric illness, 1,300 for tuberculosis, and 864 for general medical conditions. By September 1919, total numbers under treatment had increased to 6,135, with the breakdown of conditions remaining relatively consistent, though TB had overtaken mental illness as the most common condition; more than 2,200 veterans were being treated for tuberculosis, approximately 2,100 for “neuro-

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Insurance Bureau and Veterans Bureau, 1917-1923, Record Group 90, Box 7, NC-34, Entry 23, National Archives and Records Administration, College Park, Maryland.

psychosis,” and another 1,800 for other medical conditions.<sup>47</sup> In February 1920, the total number of BWRI beneficiaries being treated in PHS hospitals had ballooned by approximately 85 percent since nine months prior, to slightly more than 11,600 patients. Tuberculosis continued to be the most common ailment – almost 4,300 patients were under treatment for the disease in the winter of 1920 – while more than 3,800 were hospitalized with neuro-psychiatric illness, and another 3,590 with general medical conditions.<sup>48</sup> By May 1920, the BWRI had rated some 205,000 veterans with some degree of disability.<sup>49</sup>

The relationship between the BWRI and PHS was a complicated one, with the former acting as administrator of services and the latter as executor. When soldiers were discharged from a military hospital, their case files were sent from the army to the Washington D.C. BWRI office. According to BWRI head R.G. Cholmeley-Jones, his organization followed up by sending an application for future benefits and medical care to each disabled veteran. Many never replied, but those who did were sent, at government expense, to be examined by a local PHS doctor. That physician filled out a report regarding the former service member’s condition, and sent it back to the BWRI, which then handed down one of four possible disability ratings: total temporary, total permanent, partial temporary, or partial permanent. In the case of the latter two ratings, the veteran was assessed with a certain percentage of disability, based on the degree to which the BWRI officer believed the condition hindered the individual’s ability to be gainfully employed.

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<sup>47</sup> "Report of the Medical Division for the Quarter Ending September 30, 1919", 1919. Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans Bureau, 1917-1923, Record Group 90, Box 10, NC-34, Entry 23, National Archives and Records Administration, College Park, Maryland.

<sup>48</sup> "Report of Referred Cases and Hospital Standings, Medical Division, for the Week Ending Feb. 26, 1920", 1920. Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans Bureau, 1917-1923, Record Group 90, Box 8, NC-34, Entry 23, National Archives and Records Administration, College Park, Maryland.

<sup>49</sup> Hearings before the Subcommittee of the Committee on Appropriations, United States Senate, H.R. 13870, Sixty-Sixth Congress, Second Session, (Washington, D.C.: Government Printing Office, May 14, 1920), 5-8.



As BWRI Director Cholmeley-Jones put it, “the loss of a finger may be 12 per cent, but on account of the effect of the loss of his finger upon his vocation as a violinist they may possibly give him a temporary rating of 40 per cent.” The rating could change over time, Cholmeley-Jones said, based on the ex-soldier’s progress in vocational training and his ability “to do something else.” As per the War Risk Insurance Act, monthly payments were based both on the individual’s percentage of disability, as well as his economic position as breadwinner. A veteran with a disability rating of twelve percent who was married, for example, would receive twelve percent of \$100, whereas a veteran with the same rating who had no so-called dependents would receive twelve percent of \$80. An ex-soldier who required hospitalization could report to a Public Health Service hospital, an institution contracted with the Public Health Service, or, if necessary, a private hospital, which would then send the bill to the BWRI. While being treated, he not only had his medical costs covered, but also (much to the chagrin of some members of Congress), received disability payments equal to beneficiaries with a temporary total disability “because he is out of employment and in the hospital.” In the case of the soldier with no dependents who had a twelve percent disability, for example, compensation would increase from \$9.60 per month (or 12 percent of \$80) to \$80 while he received hospital treatment.<sup>50</sup>

As BWRI officials attempted to set and abide by rules, PHS representatives tried to decipher the nature of the organization with which they were doing business, and they found much to be desired. In an April 1919 report, Senior PHS Surgeon Claude H. Lavinder and Surgeon Wade H. Frost described their findings following conversations with representatives of

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<sup>50</sup> Ibid., 5-15. For a trenchant analysis of the somewhat arcane disability rating system, see K. Walter Hickel, “Entitling Citizens: World War I, Progressivism, and the American Welfare State, 1917–1928” (Ph.D. Dissertation, Columbia University, 1999 ), 133-42. Hickel argues that WRIA laws and regulations allowed disability to be conceived as a “medical category.” A lengthy disability rating schedule ensured that “disability benefits were to be based not on self-presentation and explanation by the veteran himself, or on social values prescribing the abilities and capacities an adult male could be expected to possess, but on the identification of an objective impairment by individual medical examination and diagnosis.”

the Medical Section of the BWRI. They pointed out that the latter organization received between 300 and 600 claims per day, and was unable to estimate the volume of work to be expected during the following six months. The BWRI Medical Section at the time consisted of eight commissioned PHS officers, Lavinder and Frost reported, who each oversaw one Section division (classified by disease or disability, such as internal medicine and tuberculosis), and about 60 support personnel. When the claims division received a patient's information, its representatives forwarded the records on to the medical officer overseeing the specific condition presumably affecting the veteran. In some cases, the officer could provide his opinion based on the paperwork at hand, but since "not infrequently" medical records were missing, the officer in question sometimes referred claimants to be examined at a PHS dispensary office or hospital. If none was locally accessible, the ex-soldier was referred to an American Medical Association physician in the vicinity. Lavinder and Frost pointed out that no clear guidelines existed regarding how to rate a disability and apply terms such as "total disability, temporary or permanent," and the accepted rating of partial disability "undetermined in degree" did little to definitively close cases. Furthermore, they noted, there was "no definite and mutually binding agreement" between the BWRI and the PHS regarding various matters, including the extent to which facilities of the PHS were to be used by the BWRI. Such a loose arrangement was problematic, the authors argued, because it stipulated that the Public Health Service must shoulder "the responsibility of providing ample facilities, while it imposes upon the Bureau of War Risk Insurance no obligation to make use of them." There was abundant confusion, Lavinder and Frost said, "as to definite policies regarding the establishment of specialized institutions and the provision of specialized services by the Public Health Service," as well as "regarding methods of procedure in many matters such as the transfer and transportation of

patients, reimbursements, etc.” The PHS and BWRI, they suggested, needed to come to an agreement about “their respective jurisdictions.” The report also highlighted shortfalls in the PHS-BWRI partnership pointed out by BWRI Medical Advisor Charles Banks: PHS facilities were “frequently inadequate and the tact and judgment displayed by officers of the Service in dealing with patients referred to them was frequently very faulty; with the consequence that (the BWRI) office was constantly in receipt of complaints from patients...”<sup>51</sup>

Lavinder and Frost’s report concluded with some measured optimism and a call to action. The Medical Section of the BWRI, the authors pointed out, had been working with inadequate staff and little time for planning and deliberation. With a recently increased staff, the authors posited, would come improvements in operations.

“Considering all the difficulties which have been encountered, the present organization is perhaps as good as might reasonably be expected,” they noted. Still, Lavinder and Frost argued, if present “deficiencies” were not corrected, they would “afford justification for very serious criticism...” Namely, they noted, the BWRI must compile more complete statistics, and equip itself to predict future workload. It also must clearly instruct examining medical officers to avoid the twin problems of inconsistent diagnoses and the necessity for re-examinations of claimants. Lastly, Lavinder and Frost highlighted the need for definitive and “scientific” standards for defining terms such as “total” and “partial” disability, as well as the unfortunate lack of a “systematized and clearly

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<sup>51</sup> "Memorandum for the Surgeon General, U.S. Public Health Service, on a Survey of the Organization and Administration of the Office of the Chief Medical Advisor of the Bureau of War Risk Insurance, with Reference to Its Relations to the Public Health Service", April 21, 1919. Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans Bureau, 1917-1923, Record Group 90, Box 7, NC-34, Entry 23, National Archives and Records Administration, College Park, Maryland.

understood plan of cooperation” between the PHS and BWRI.<sup>52</sup> BWRI officials echoed the sentiment: W.G. Stimpson, Chair of the BWRI’s Service Board, which had been appointed to consider hospital sites for the bureau’s patients – told the PHS Surgeon General in April 1919 that the board had voted to suspend itself until the two organizations could definitively define their relationship.<sup>53</sup>

The call for a formal agreement between the BWRI and PHS was answered with the drafting of a six-page memo outlining the responsibilities of each organization. The May 1919 document stated that the BWRI must provide necessary statistics for the PHS to carry out its work, but it left unclear exactly who would set the guidelines for the record-keeping. It also failed to answer the question of how and when the organization was to disseminate information. The PHS was to supply adequate staff and facilities to fulfill its duties to the BWRI, the agreement said, but with what funding and with how much autonomy? At the time the memo was drafted, the PHS was in the process of organizing the United States into 14 districts, which would match those in place under the auspices of the Federal Board for Vocational Education, the BWRI, and the army. One PHS officer would be in charge of each district and would coordinate local claimants’ medical and hospital needs. In most cases, the proposed agreement declared, claimants should be supplied medical care close to their home districts, though it was acknowledged that long-distance travel to large-scale special hospitals for the treatment of psychoneuroses, tuberculosis, and perhaps orthopedic surgery, may be necessary. In spite of the memo’s

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<sup>52</sup> Ibid.

<sup>53</sup> "Letter from W.G. Stimpson to Surgeon General, United States Public Health Service", April 24, 1919. Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans Bureau, 1917-1923, Record Group 90, Box 11, NC-34, Entry 23, National Archives and Records Administration, College Park, Maryland.

stipulations about organizational roles, the document did little more than re-state the general framework of previous, vague legislation, and left some of the most difficult questions about jurisdiction unanswered.<sup>54</sup>

The agreement draft was more remarkable for its very existence – and its silences – than for its accomplishments. It reveals that well after the Armistice, although legislation had been passed intending to make government-sponsored medical care a reality for ex-soldiers, it remained highly problematic to administer it.

A November 1919 statement from the BWRI about how it was “meeting the herculean problem of examining, rating and returning the physical usefulness minds and bodies wrecked in the Great War” describes how officials wished the organization could function, and showcases the difference between reality and ideal. The Bureau reported that it was handling a “maze of intricacies” resulting from the War Risk Insurance Act’s guarantee of medical care for all soldiers who incurred disability in service, and it was doing it nobly and efficiently. The burden of proof regarding service connection of an injury or illness was always on the government, the statement said, with the benefit of the doubt given to the ex-service member in every instant. Claims were handled expeditiously by “specially trained” Public Health Service officers in one of eight sections of the Medical Division – internal medicine, surgery, tuberculosis, neuro-psychiatry, eye, ear, nose, throat, and dental, prosthetics, statistical, and miscellaneous – who processed 5,000 claims per day. The officers rated disabilities, and secured medical equipment and institutional care. “Side by side, and handled in exactly the same way, are the cases of

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<sup>54</sup> "Memorandum of an Agreement between the Director, B.W.R.I. And the Surgeon General of the P.H.S. Relative to Cooperation between Their Respective Bureaus in the Discharge of the Duties and Responsibilities Placed Upon Said Bureaus by the Provisions of Public Act No. 326, and the War Risk Insurance Act", May 9, 1919. Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans Bureau, 1917-1923, Record Group 90, Box 11, NC-34, Entry 23, National Archives and Records Administration, College Park, Maryland.

Colonels, Captains and Corporals; white men, colored men and Indians; men who have no English – men who are illiterate, and men who have received their education at the finest institutions of learning...” the BWRI reported.<sup>55</sup>

To enhance the highly idealized image of government-sponsored medical care, the Bureau report supplied examples of individual cases. There was a man who suffered from shell-shock, “having been blown up with high explosives in Belleau Wood,” who contacted the Medical Division to report that the noise of plumbers pounding on pipes while his apartment was being remodeled “fair makes me nutty.” The BWRI expeditiously had the veteran sent, with an attendant, to a newly opened “psychopathic hospital” at Cape May, New Jersey, “where he received careful attention and accurate scientific treatment...” Within a few weeks, the patient was “happy, contented,” and “doing splendidly in a business college where he was taking a course at the hands of the Federal Board for Vocational Education.” Other cases were cited, including that of a “shy, timid mother” who sought help for her son; he ““really isn’t crazy... he just hears voices,”” she told a Bureau agent. The mother’s “aching heart” was somewhat “lightened” when the BWRI secured a spot for the young man at a Public Health Service Hospital in Denville, New York. There was also the case of a young ex-soldier who had shrapnel lodged in the base of his skull and required special surgery. He was shipped, at government expense, to a far-away hospital, placed under the care of a specialist, and provided with round-the-clock attendant and nurse care. Eventually, he was operated on with great success. The BWRI report acknowledged that “time once was when letters were not answered as promptly as they are now,” but “now the work of the Medical Division is and has been for some time absolutely current.” Although it was clear that “the problem of hospitalizing the patients of

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<sup>55</sup> Bureau of War Risk Insurance Treasury Department, "Medical and Surgical Relief for War Heroes" November 16, 1919, Ibid. Record Group 90, Box 7, NC-34, Entry 23,

the War Risk Insurance Bureau is an enormous one,” the report maintained that the BWRI and PHS were working in concert to see that challenges were met.<sup>56</sup>

PHS administrators also shared success stories regarding how their organization functioned in respect to disabled and ill veterans. According to a 1920 article in Walter Reed Army General Hospital’s newspaper, *The Come-Back*, in the New York, New Jersey, and Connecticut district, the PHS was caring for about 100,000 ex-service members, 6,000 of whom were being treated in hospitals and sanatoria, 200 in convalescent homes, and the remainder as out-patient beneficiaries of the Bureau of War Risk Insurance. When veterans reported to PHS offices in the tri-state area, they were examined, then their case records were sent to the Bureau of War Risk Insurance in Washington, DC. There, officials determined how much of a monthly allowance to allot during medical treatment. Ex-service members were then required to report “at regular intervals for re-examination,” and, the article reported, “the follow-up system of the Public Health Service keeps constantly in touch with those who fail to appear.” Dr. Cooke, the supervisor of the New York office of the PHS, told *The Come-Back* that he felt that if veterans complained about government services, they “should always receive the benefit of the doubt.”<sup>57</sup>

Behind public statements of confidence in a robust and productive BWRI-Public Health Service partnership, however, major systemic problems existed. One, regarding whom, exactly, was eligible for treatment in PHS hospitals, came to the fore soon after Public Law 326 was passed in March 1919. According to the law, the PHS was “authorized to provide immediate additional hospital and sanatorium facilities for the care and treatment of discharged sick and disabled soldiers, sailors, and marines, army and navy nurses (male and female), patients of the

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<sup>56</sup> Ibid.

<sup>57</sup> “Public Health Handling Large Job Efficiently,” *The Come-Back* November 20, 1920.

War Risk Insurance Bureau...” Some PHS officials interpreted the clause to mean that *all* discharged sick and disabled veterans, not only those who had received a disability rating from the Bureau of War Risk Insurance, were eligible to receive medical care. In August 1919, Dr. Bert Caldwell, Senior Surgeon for the PHS in Chicago, Illinois, wrote to William C. Rucker, a career Public Health Service officer temporarily serving as the BWRI Chief Medical Advisor. He wondered whether he and his staff were obligated to treat patients with the flu or gonorrhea, by virtue of the fact that they were veterans.

Rucker’s reply, which cited both the War Risk Insurance Act and Public Law 326, was less than definitive, mainly because those two laws, in some senses, contradicted each other. Under the War Risk Insurance Act, Rucker explained, a claimant had to be compensable by the Bureau of War Risk Insurance before he could receive treatment. He based his argument on the fact that the law stated that, “*in addition to the compensation above provided*, the injured person shall be furnished by the United States... governmental medical, surgical, and hospital services...” But, Rucker continued, no compensation was provided for ex-soldiers whose injuries or illnesses resulted from their own “willful misconduct,” which, he implied, may bring on bouts of gonorrhea or the flu. Rucker also pointed out, however, that Public Law 326 was “far broader in its scope” than the War Risk Insurance Act in its provision for veterans seeking medical care. It was apparently designed, he said, “to care for any person who could show that he had been discharged from the military or naval forces of the United States and was sick or disabled.” The entire question, Rucker said, was before the Attorney General, who would henceforth notify the PHS of its decision.<sup>58</sup> There, Rucker’s letter ended, leaving Caldwell and other PHS officials in

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<sup>58</sup> "Letter from W.C. Rucker, Chief Medical Advisor, Bureau of War Risk Insurance, to Senior Surgeon Bert W. Caldwell, U.S. Public Health Service, Supervisor of District No. 8, Chicago, Illinois", August 25, 1919. Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans Bureau, 1917-1923, Record Group 90, Box 7, NC-34, Entry 23, National Archives and Records Administration, College Park, Maryland.



the same predicament they had faced since the law was passed five months prior: if they refused to treat patients who were not compensable by the BWRI, they may be acting outside the law. But if they did treat them, it was unclear whether and how the government would compensate physicians or institutions for services rendered.

In September 1919, Acting Attorney General Charles B. Ames wrote to Secretary of the Treasury Carter Glass to report on his ruling regarding the question at hand, and eligibility for medical care. "It was not intended that every soldier who had been discharged and who should afterwards happen to be sick and disabled should be entitled to the benefits of the Act," he said. Only those who had become sick or disabled in the line of duty were compensable by the BWRI, he said, and only those individuals were eligible for government-sponsored medical treatment.<sup>59</sup>

The debate over the wording of Public Law 326 makes it clear that bureaucrats in both the PHS and BWRI were constrained and confused by sloppily conceived of and written legislation. It also shows that the question of whether treatment should be given for non-line-of-duty injuries arose soon after ex-soldiers' hospital care was deemed a societal responsibility. The Attorney General's ruling did not signal the end of confusion; the point was continually debated throughout the early 1920s.

#### *A blueprint for the future: Estimates of massive need*

As their bureaucratic troubles escalated, PHS Surgeon General Rupert Blue and BWRI Chief Medical Advisor William C. Rucker brought their concerns to Congress, where they argued that more and better publicly funded medical care was needed for

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<sup>59</sup> "Letter from C.B. Ames, Acting Attorney General, to Honorary Carter Glass, Secretary of the Treasury", September 2, 1919. Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans Bureau, 1917-1923, Record Group 90, Box 7, NC-34, Entry 23, National Archives and Records Administration, College Park, Maryland.

World War veterans. In House Document 481, which was referred to repeatedly in debates regarding veterans' care during the next few years, they presented a statistics-laden case for the idea that the problem of veterans' medical care posed a great long-term challenge. Blue and Rucker argued that the resources at hand were insufficient and ill-conceived, and that a total of 30,660 beds – 7,200 for general, medical and surgical conditions, 12,400 for tuberculosis, and 11,060 for neuro-psychiatric patients – would be necessary to treat BWRI patients in the years to come. In addition, they requested that 200 outpatient clinics be established, where state and PHS health officials would work together in a group practice model resembling that in place at Minnesota's famed Mayo Clinic. At the clinics, medical specialists would see patients before and after hospital visits – ideally, the clinics would cut down on the need for hospitalization. Blue and Rucker estimated that \$85.5 million in government funding would be required to fulfill the requests.<sup>60</sup>

Evidently presupposing some skepticism from congressional representatives, Surgeon General Blue offered various justifications for the need for beds and clinics. First, there were the raw numbers: patient load was constantly growing – between April and October, 1919 PHS hospitals saw an increase of approximately 140 BWRI patients per week. Blue also noted that Public Law 326 stipulated that the PHS should make use of abandoned military hospitals for treatment of BWRI patients, but bureaucrats who had initially told congressional representatives that discharged service men and women would be unwilling to seek treatment at those facilities had, in fact, been proven correct; the PHS had ceased operations at all but two of the military hospitals in which it once

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<sup>60</sup> Additional Hospital Facilities for Discharged Soldiers, Sailors, Marines, and Army and Navy Nurses, House Document No. 481, 1-8.

admitted patients. Now, new facilities were needed to replace those. Blue also pointed out that the most recent request for funding was not spontaneous, but instead, long foreseen by experts. In the lead-up to the passage of Public Law 326, Blue said, “it was stated many times to many Congressmen that this was only the beginning of what would be the requirements to make adequate provision for the patients of the War Risk Insurance Bureau.”<sup>61</sup>

But given the fact that when Blue presented his data, only 3,100 War Risk Insurance patients were being treated in PHS hospitals and 3,200 in civil institutions under contract with the government, the estimated eventual need for more than 30,000 beds seemed to necessitate a more extensive explanation.<sup>62</sup> Blue said that peak patient loads for some neuro-psychiatric illnesses would not be reached until the late 1920s, and a need for services would be sustained for decades thereafter. It was preferable, he noted, to treat both neuro-psychiatric and tubercular patients in government institutions, as opposed to civil contract institutions, since the latter were “for the most part overcrowded and inadequate to meet the needs of the civilian population, without being forced to care for the large number of cases which have resulted from and have been discovered during the recent war.” Although he acknowledged that some regions of the country were overwhelmed with BWRI cases while others had a plethora of empty beds, Blue maintained that institutions serving veterans had to be spread throughout the U.S. so that patients could be treated near family and friends.<sup>63</sup>

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<sup>61</sup> Ibid., 3-7.

<sup>62</sup> Ibid., 10.

<sup>63</sup> Ibid., 11-15.

As he reported that the PHS and BWRI were lacking in resources, the Surgeon General also argued that a law should be enacted to “care for all discharged soldiers and sailors,” not just those who had been discharged with a disability rating of at least ten percent. In so doing, he brought up an idea embraced by emerging veterans’ groups, one that would shape the future veterans’ medical system. The “burden of proof” was on the government concerning those who claimed that their disease was aggravated by or incurred in the service, Blue said. Furthermore, he added, the government was also obligated to treat those who had newly emergent diseases they claimed were connected with their time in the service. Beyond providing a legal basis for offering medical treatment to all veterans, he offered an economic rationale: Providing care to all who served during the war, Blue said, will “operate to save the government millions of dollars in preventing or deferring the payment of compensation and insurance claims. Harkening back to pre-war arguments about using medical care as a means to maintain industrial productivity, he argued that it made good business sense to provide “medical supervision for such a large portion of the population at the greatest productive age period.”<sup>64</sup> Blue’s opinion regarding comprehensive veterans’ health care jibed with his perspective on compulsory health insurance for the larger population – an issue gaining increasing attention from policy makers and medical professionals in the first decades of the twentieth century. In 1916, when Blue served as both PHS Surgeon General and president of the American Medical Association, he predicted, “health insurance will constitute the next great step in social legislation.”<sup>65</sup>

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<sup>64</sup> Ibid., 17.

<sup>65</sup> The quote is cited in Forrest A. Walker, "Compulsory Health Insurance: "The Next Great Step in Social Legislation", " *The Journal of American History* Vol. 56, No. 2(Sep. 1969). For background on debates in this period

Blue's assessments of veterans' needs were based in part on an October 1919 report from William C. Rucker, to Assistant Secretary of the Treasury James H. Moyle.<sup>66</sup> By way of introduction, Rucker said, "the entire problem is one without precedent in history." Although it was difficult to predict with statistical accuracy what the exact future demand for medical services would be, he argued, "the problem will grow with time rather than diminish, and... if mistakes are made they are far more apt to be in the direction of underestimating rather than of overestimating the magnitude of the situation..." He offered as partial evidence for his claim the massive increase in numbers of pension requests by Civil War veterans between 1861 and 1897 – an argument pre-war policy shapers had so adamantly hoped would never arise in relation to the present conflict.<sup>67</sup>

Rucker also offered a variety of statistical evidence demonstrating the ever-growing need for more resources and funding. Of more than four million mobilized troops, he said, slightly more than 640,000 qualified as potential BWRI claimants, 425,100 of whom had been discharged as disabled. An additional 16,500 limited-service men were called but rejected due to disabilities upon arrival at camps. Finally, there were 200,300 men who were accepted by local draft boards but rejected by camp surgeons due

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regarding compulsory health insurance, see Alan Derickson, *Health Security for All: Dreams of Universal Health Care in America* (Baltimore, Maryland: Johns Hopkins University Press, 2005). Baeatrix Hoffman, *The Wages of Sickness: The Politics of Health Insurance in Progressive America* (The University of North Carolina Press, 2001). Ronald L. Numbers, *Compulsory Health Insurance: The Continuing American Debate* (Westport, Connecticut: Greenwood Press, 1982).

<sup>66</sup> Bess Furman argues that Blue had a hand in authoring the report. Furman, *A Profile of the United States Public Health Service, 1798-1948*, 332.

<sup>67</sup> Additional Hospital Facilities for Discharged Soldiers, Sailors, Marines, and Army and Navy Nurses, House Document No. 481, 28-30.

to physical disability. Rucker predicted that the largest proportion of patients – 25 percent, or around 79,000 – would be discharged with “diseases of the nervous system and mental alienation”; another 25 percent, or 78,930 would have diseases of the circulatory system. 13.4 percent or 41,970 ex-servicemen, he said, would be discharged with “diseases of bones and organs of locomotion”; 12.8 percent or 40,090 with “general diseases”; 10.1 percent or 31,630 with tuberculosis; and nine percent or 28,190 with venereal disease. Many of the most prevalent disorders, Rucker noted, would require treatment for many years. “Psychoneurotic” patients, for example, could be treated successfully, but then need to be re-admitted in subsequent years in the event of reoccurrences.<sup>68</sup> Tuberculosis also posed a long-term challenge, according to Rucker. 46,000 cases of TB were expected to arise in the coming years, and it would be difficult to prove that they were not connected to service. If government policy was amended to include all veterans of the war – and not just those who were discharged with a disability rating of ten percent or more – the BWRI and PHS could be liable to treat more than 300,000 cases of TB.<sup>69</sup>

In spite of this daunting caseload number, Rucker joined Blue in arguing that all veterans of the war should be eligible for government sponsored medical care. First, he

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<sup>68</sup> Ibid., 28-37.

<sup>69</sup> Ibid., 28-42. Rucker’s estimates of future need included all branches of the military service. The numbers he put forth for “known demobilized disabled” from the army were considerably higher than the official tally released by the Army Medical Department in the early 1920s. H. Doc. 481 said that 129,900 were discharged as disabled from the army in 1917 and 1918. It approximated that another 156,000 would be discharged as disabled in 1919. In 1922, the army reported that a total of 204,765 soldiers were discharged from service as physically or mentally unfit for military duty. Albert G. Love, “A Brief Summary of the Vital Statistics of the U.S. Army During the World War,” *The Military Surgeon* Vol. LI, Number 2(August 1922). Love offers a more in-depth portrait of statistics in: ———, *The Medical Department of the United States Army in the World War, Volume Xv, Part Two: Medical and Casualty Statistics* (Washington, D.C.: Government Printing Office, 1925). See the Introduction and Chapter Two for more data on numbers of and reasons for discharges. Chapters Six and Seven will discuss estimated needs and actual hospital utilization.

noted that in claims filed with the BWRI, it had become clear that discharge ratings were not always accurate. Sometimes, he said, medical records proved that there was an extensive physical disability upon completion of service, but none noted by the discharge board. Also, he said, “many service men clamored for their discharges after the Armistice, and were discharged in a disabled condition because they had developed what might be termed ‘hospital phobia’ and a general dislike for the military service.” In spite of the fact that many of these ex-service members had signed away their rights to make future claims on the government, Rucker implied, they should be eligible for medical care.

Finally, Rucker also argued that each of the more than 28,000 ex-servicemen discharged with venereal disease were “potential claimants.” A recent resolution suggesting that the government was not obligated to treat an ex-service member if a disease or injury resulted from “willful misconduct of moral turpitude,” Rucker said, was legally questionable. Even though 60 to 75 percent of ex-servicemen with venereal diseases likely had the conditions prior to military service, they were accepted by local draft boards “in sound condition,” he said. “To stigmatize a man suffering from a venereal disease by saying that the disease was contracted because of his ‘moral turpitude’ when that man had obeyed the prophylactic regulations of the Army or Navy, or if that man had contracted the disease prior to his enlistment in the service,” Rucker argued, “would be a task which no court or man would care to undertake or discharge with justice.” Furthermore, he noted, treating BWRI beneficiaries with venereal diseases made practical sense. It would be difficult for the government to prove that a variety of diseases that could arise from conditions like syphilis and gonorrhea were linked to a pre-

existing condition, as opposed to one contracted during service. Staving off clearly compensable disorders, Rucker suggested, was practical, if nothing else.<sup>70</sup>

As Rucker and Blue made their case, they were laying the groundwork for later arguments that all veterans should receive government sponsored medical care, not just those discharged with a line-of-duty disability. Meanwhile, the seemingly astronomical estimates of need presented via House Document 481, though not immediately acted upon, helped pave the way for future appropriations.

*Interagency squabbles, questions regarding eligibility, and patients as heroes or “parasites”*

In 1919 and 1920, as patients and their case files were transferred from one government agency to another, the army, BWRI, and PHS each had a vested interest in and responsibility for some aspect of veterans’ care. Coordinating activities to ensure that the sundry promises of the U.S. government were met proved a significant challenge. Indeed, representatives of each branch harbored suspicions about the veracity of the efforts of their counterparts in other agencies.

Army officials, for example, reported trepidation about sending officers to PHS facilities they deemed inferior to state-of-the-art military hospitals. In April 1920, Secretary of War Newton D. Baker wrote to Army Chief of Staff Peyton C. March expressing his worry about a policy dictating that all hospitalized wartime emergency officers and soldiers be discharged from

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<sup>70</sup> Additional Hospital Facilities for Discharged Soldiers, Sailors, Marines, and Army and Navy Nurses, House Document No. 481, 45-47. Similar questions arose surrounding the issue of providing medical care for drug addiction. In December 1920, for example, an executive officer in the PHS Section of Neuro-Psychiatry, V.L. Mahoney, wrote to the Medical Division of the BWRI to inquire whether one Simon G. Snell was “a bona fide beneficiary of the Bureau of War Risk Insurance, and entitled to care and treatment by the Public Health Service.” Snell, Mahoney pointed out, was “suffering from drug addiction alleged to have occurred in the line of duty.” The BWRI, said the PHS official, should determine whether the “present addiction to the drug is the result of his own willful misconduct.” “Letter from Surgeon General's Office, Section of Neuro-Psychiatry, U.S.P.H.S., to Acting Assistant Director in Charge, Medical Division, B.W.R.I.,” December 8, 1920. Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans Bureau, 1917-1923, Record Group 90, Box 10, NC-34, Entry 23, Folder: Bureau of War Risk Ins. Carbons, Sep. 1 to Dec. 30, 1920, National Archives and Records Administration, College Park, Maryland.



army hospitals by June 30, 1920. Focusing on the original mandate handed to the army prior to the war – that soldiers be discharged only once they were fully rehabilitated– Baker wondered, “Would it not be wise to ask Congress for some sort of legislative authority to retain those who have not at such time achieved the maximum benefit possible from medical and surgical care in Army hospitals?”<sup>71</sup> After all, he argued, “there will be a few officers and maybe a few enlisted men in the hospitals like Walter Reed and Letterman where we have unusual facilities for highly specialized treatment, which can not be expected to be provided with the same degree of efficiency by the Public Health Service.” Baker implied that the military harbored a weighty and lasting obligation to provide for its recruits: “I would not like to have the Army put in the position of turning these men adrift or subjecting them to less favorable conditions for recovery than retention in the Army hospitals would provide.”<sup>72</sup> Baker, in fact, was so concerned that the Public Health Service was incapable of providing the care veterans needed that he volunteered the army to go above and beyond its prescribed duty.

The army’s Assistant to the Chief of Staff, Henry Jervey, was considerably more conservative in his estimation of military responsibility. The army, he said, “should free itself as soon as practicable of the prolonged care of disabled persons, turning them over to the agencies approved by Congress to provide for their care, thus permitting the Medical Department to devote its energies to the normal and proper duties for which it is provided as a part of the military establishment.” Those duties included caring for disabled personnel during war, but not

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<sup>71</sup> "Memorandum for General March, from Newton D. Baker, Secretary of War", April 17, 1920. Records of the War Department, General and Special Staffs, Correspondence of War College Division and Related Gen. Staff Offices, 1903-1919, Record Group 165, Microfilm 1024, Roll 346, National Archives and Records Administration, College Park, Maryland. "Memorandum for General March, from Newton D. Baker, Secretary of War".

<sup>72</sup> "Memorandum for General March, from Newton D. Baker, Secretary of War", April 27, 1920. Records of the War Department, General and Special Staffs, Correspondence of War College Division and Related Gen. Staff Offices, 1903-1919, Record Group 165, Microfilm 1024, Roll 346, National Archives and Records Administration, College Park, Maryland.

afterwards. After all, he noted, “Congress has made no provision for the maintenance of the large medical establishment that would be necessary to continue the care and treatment of the large number of disabled persons resulting from the war.”<sup>73</sup> Although Jervy recommended against asking permission from Congress to retain disabled men in the army so they could remain under the auspices of the Army Medical Department, he tacitly agreed with the point that military hospitals were, in many cases, superior to those of the PHS. Ex-officers, he reassuringly noted, could continue to receive care in some of the finest army hospitals even after discharge – that care would simply be funded by the BWRI.<sup>74</sup> It was clear that some army officials continued to operate under the assumption that the military had an obligation to discharged service members, but they were forced into the uncomfortable position of rescinding control to outside agencies.

Meanwhile, PHS officials had similar ill feelings about army facilities. In reply to a letter from the Director of the BWRI querying why the PHS was not making use of empty beds in army and navy hospitals on a contract basis, Hugh S. Cumming, appointed the Surgeon General of the PHS in March 1920, frankly stated that his organization’s attempts to utilize such beds had “not been productive of desirous results.” PHS field officers reported that military hospitals denied admission to patients suffering from tuberculosis, mental and nervous disorders, venereal diseases, and other conditions. The so-called empty beds, Cumming argued, were thus limited “to a very narrow class of patients.” Plus, he noted, ex-service members resisted the notion of being treated in military facilities “because of the discipline imposed on them while in such

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<sup>73</sup> "Memorandum for the Chief of Staff, from Henry Jervy, Major General, General Staff", April 23, 1920. Records of the War Department, General and Special Staffs, Correspondence of War College Division and Related Gen. Staff Offices, 1903-1919, Record Group 165, Microfilm 1024, Roll 346, National Archives and Records Administration, College Park, Maryland.

<sup>74</sup> "Memorandum for the Chief of Staff, from Henry Jervy, Brigadier General, Gen. Staff", May 5, 1920. Records of the War Department, General and Special Staffs, Correspondence of War College Division and Related Gen. Staff Offices, 1903-1919, Record Group 165, Microfilm 1024, Roll 346, National Archives and Records Administration, College Park, Maryland.

institutions.”<sup>75</sup> The statements of the War Department’s Baker, and Cumming, of the Public Health Service, demonstrate that members of separate branches of government harbored a distinct lack of confidence in other branches.

In early 1920, officials openly discussed the urgency of the situation. At a conference between the BWRI and PHS, BWRI Director Richard G. Cholmeley-Jones, welcomed attendees, noting that, throughout the bureau, there was “a feeling of great intimacy” with the PHS. The two organizations, he said, had “many mutual problems to solve.” “I have heard some people remark that war was hell, but the after-war effects were ‘heller,’” Cholmeley-Jones said, proposing that post-war challenges were more drastic than wartime ones. “It is one of the most difficult things to build up an organization, an efficient organization...” Cholmeley-Jones urged his colleagues to imagine no “dividing line in the work we are doing. We have one man or woman to serve...”<sup>76</sup>

Judging by the comments of both BWRI and PHS officials at the meeting, however, there were a great many dividing lines and questions. PHS representatives brought up a number of concerns, including questions about the rights of veterans. What if, for example, a patient requested to be transferred in order to be closer to family? That was an issue that “had to be borne with as patiently as possible, and everything must be

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<sup>75</sup> "Letter from H.S. Cumming, Surgeon General, to Director of the War Risk Insurance Bureau, Washington, D.C.", March 5, 1921. Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans Bureau, 1917-1923, Record Group 90, Box 9, NC-34, Entry 23, National Archives and Records Administration, College Park, Maryland.

<sup>76</sup> "Minutes of a Conference between the Public Health Service and the Bureau of War Risk Insurance", 1-2.

done to keep the patient satisfied,” Cholmeley-Jones said. If a bed was available at the desired institution, the patient should be moved as soon as possible.<sup>77</sup>

The BWRI policy led to great difficulties in administration. For example, in an October 1920 letter to Cholmeley-Jones intended to answer complaints about a shortage of hospital facilities in Oklahoma, PHS Surgeon General Hugh S. Cumming noted that his organization “had always offered to hospitalize anybody sick in Oklahoma, and up to this time have been successful in doing so, provided they would accept facilities in another state.” Cumming argued that it was “impossible... for us to guarantee to hospitalize the inhabitants of each state within the boundaries of that state, regardless of the complaint with which they suffer. I do not see how the National Government could undertake to establish hospitals for every type of case in every state in the Union...”<sup>78</sup>

According to the PHS official in charge of the tuberculosis sanitarium in Tucson, Arizona, some patients took advantage of the BWRI policy to locate them according to their desires. ““Local patients,”” he reported, ““prefer to live in contract hospitals all (*sic*) account of no discipline.”” PHS Assistant Surgeon General C.H. Lavinder predicted that, in spite of overcrowding at the Tucson contract institution, and the existence of a vast number of empty beds at the PHS facility in the same town, there would be “some difficulty in removing patients from the contract hospitals to the government hospitals.”

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<sup>77</sup> Ibid., 12. This portion of the meeting minutes is not directly transcribed, but written up as a report of proceedings. The direct quote from the minutes is: “The Director stated that this was one of those unpleasant things which had to be borne with as patiently as possible, and that everything must be done to keep the patient satisfied. If a patient wanted to be transferred to another hospital and if there was an available bed, transfer him; if not, explain matters to him and tell him as soon as there was a vacancy he would be transferred.”

<sup>78</sup> "Letter from H.S. Cumming, Surgeon General, P.H.S., to Director of B.W.R.I.", October 20, 1920. Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans Bureau, 1917-1923, Record Group 90, Box 8, NC-34, Entry 23, National Archives and Records Administration, College Park, Maryland.

He also noted that similar conditions existed in Saranac Lake, New York, Albuquerque, New Mexico, and “scores of health resorts throughout the United States.”<sup>79</sup>

Further to this point, PHS officials evidently found Great War veterans to be somewhat high-maintenance. At the April 1920 conference between the BWRI and PHS, one doctor noted that many District Supervisors had observed “a tendency toward snobbishness in some of the soldiers. Because they were ex-soldiers, they thought they were a little better than other patients, especially the charity ones.” To this, the BWRI Chief Medical Advisor could only reply, “This whim should not be encouraged. If allowed to exist, we would create a fine set of parasites.”<sup>80</sup>

Both PHS and army officials questioned whether patients deserved to be treated as soldiers, charity cases, or heroes. They had been told by BWRI Chief Medical Advisor, William C. Rucker in December 1919 that it was “exceedingly improper to issue orders” that a patient be moved to a different hospital, as opposed to “requesting” that he proceed there.<sup>81</sup> But there was resistance to such a sentiment: In February 1920, the Commanding Officer of U.S. Army Hospital Number 21 in Denver, Colorado reported to the Army Surgeon General that “civilian soldiers” were an especially “difficult class of patients:”

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<sup>79</sup> "Letter from Assistant Surgeon General C.H. Lavinder, to Assistant Director in Charge of Medical Division, B.W.R.I.", March 17, 1921. Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans Bureau, 1917-1923, Record Group 90, Box 10, NC-34, Entry 23, Folder: BWRI carbons Jan. 1st to Mar. 31st, 1921 National Archives and Records Administration, College Park, Maryland.

<sup>80</sup> "Minutes of a Conference between the Public Health Service and the Bureau of War Risk Insurance", 12.

<sup>81</sup> "Letter from W.C. Rucker, Assistant Surgeon General, U.S.P.H.S., Chief Medical Advisor, B.W.R.I., to Surgeon General, U.S.P.H.S.", December 2, 1919. Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans Bureau, 1917-1923, Record Group 90, Box 7, NC-34, Entry 23, National Archives and Records Administration, College Park, Maryland.

Having been petted, made heroes of, on account of their participation in the World War and the disabilities incident thereto... there is a feeling among these patients that they are not subject to ordinary discipline and have a perfect right to conduct themselves as they see fit. This condition obviously cannot be permitted to exist and, on the other hand, our actual authority for handling them is quite limited.<sup>82</sup>

At the spring 1920 conference between the BWRI and PHS, a PHS doctor summarized some of his colleagues' viewpoints regarding the attitude and social status of veteran patients. He wondered what to do about the "numerous complaints" regarding ex-soldiers in PHS hospitals who refused to complete the duties required of all patients – making their own beds, for example; "they would say, 'I saved my country from democracy (*sic*) and I will not work.'” Cholmeley-Jones suggested what might have seemed to PHS officials like a somewhat drastic measure to handle this problem; change the commanding officer of the hospital, he said, arguing that a better "disciplinarian" could often garner better results.<sup>83</sup> There was little in the response in the way of widely applicable, concrete measures to alleviate a very particular problem – a patients' lack of discipline according to PHS standards. There was also a failure to address the larger question of whether such expectations of discipline were realistic or, indeed, appropriate.

Demands from the BWRI that veterans be treated as honored civilians was likely resisted by some PHS doctors and officials who strongly felt that many bureau patients did not belong in hospitals at all. One PHS inspector reported that 80 to 90 percent of patients in hospitals he had recently visited were ambulatory and "seemed to be in

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<sup>82</sup> "Memo from C.A. Knowles, Commanding Officer of U.S. Army General Hospital No. 21, Denver, Colorado, to Surgeon General, U.S. Army, Re. Discipline of Civilian Patients", February 17, 1920. Records of the Adjutant General's Office, Central Decimal Files, 1917-1925, 704.1 to 707.2, Record Group 407, Box No. 1097, Folder: 705.15 (3-20-20) to (3-6-18), National Archives and Records Administration, College Park, Maryland.

<sup>83</sup> "Minutes of a Conference between the Public Health Service and the Bureau of War Risk Insurance", 15-16.

excellent physical condition.” Suggesting that ex-soldiers should not have unfettered access to government institutions, he argued that PHS doctors should have authority to discharge such patients in an “unimpeded” manner.<sup>84</sup> Another physician who ran a sanitarium in Fort Dodge, Iowa reported to the BWRI’s Cholmeley-Jones that “many” beneficiaries sent to his institution with diagnoses of tuberculosis did not, in fact, have the disease. In order to remain in institutions like the one in Iowa, however, at least one patient was found to be “borrowing sputum from a man who had tubercle bacilli in his sputum.” When such patients were discharged, the doctor argued, they issued complaints with the American Red Cross and veterans’ organizations, which did “all they could to discredit our work and the care which we are giving them.” Institutions were not only caring for “malingerers,” according to the physician, but they were doing so while they waited for six months or more to be reimbursed by the BWRI. The entire system, he suggested, was broken: “...many worthy, sick ex-service men” deserved to receive “every care and consideration,” he said, but “chicanery and fraud” threatened the rights of all veterans.<sup>85</sup>

A question and answer session during the April BWRI-PHS conference highlighted many holes within the system: Would the BWRI reimburse private doctors who performed medical exams on ex-service members, or only those physicians who had been approved as government examiners? Only approved examiners would be guaranteed

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<sup>84</sup> "Letter from Senior Surgeon, U.S.P.H.S., Inspector, to Surgeon General U.S.P.H.S.", September 20, 1919. Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans Bureau, 1917-1923, Record Group 90, Box 7, NC-34, Entry 23, National Archives and Records Administration, College Park, Maryland.

<sup>85</sup> "Letter from J.W. Kime, to R.G. Cholmeley-Jones, Director, B.W.R.I.", July 24, 1920. Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans Bureau, 1917-1923, Record Group 90, Box 8, NC-34, Entry 23, National Archives and Records Administration, College Park, Maryland.

reimbursement, according to a BWRI official.<sup>86</sup> Many in the room likely recognized the paradoxical implications of the stated policy: a physician might be put in the position of refusing services to an ill veteran seeking care, and a veteran might have to seek services far from home – two scenarios the BWRI repeatedly stated it was trying to avoid.

A January 1920 account from a Red Cross representative, Cora G. Irvine, provides an example of a prospective outcome of the rule. In Snohomish, Washington, Irvine reported, the designated PHS doctor kept patients waiting for hours, sometimes days, before they could be seen for an appointment, then refused to render services until an ex-soldier received approval for procedures from the Seattle office. Occasionally, patients were sent to Seattle to see doctors, often at their own expense, Irvine said. The government-approved examiner was evidently juggling his veteran-related duties with other professional functions. “For the good of the disabled man,” Irvine pleaded, “the suggestion is made that a Public Health Service physician be appointed who would give a specified time exclusively to the Public Health Service.”<sup>87</sup>

There were many other questions from PHS officials at the spring 1920 conference. What if ex-service members requested that they be re-examined, claiming that their condition had worsened? They should, according to BWRI officials, be re-examined. And what if a man was healed from a gunshot wound (the disability for which he was discharged), but now complained of the effects of tuberculosis, which had resulted from influenza incurred during service? The man should be treated, according to

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<sup>86</sup> "Minutes of a Conference between the Public Health Service and the Bureau of War Risk Insurance", 18-21.

<sup>87</sup> "Letter from Cora G. Irvine, Executive Secretary, Home Service Section, A.R.C., to Bradley Fowlkes, Representative, B.W.R.I., Seattle, Washington", January 15, 1920. Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans Bureau, 1917-1923, Record Group 90, Box 9, NC-34, Entry 23, Folder: War Risk 1919-1920, National Archives and Records Administration, College Park, Maryland.



Rucker. And, what if he had misplaced his discharge form? Have the prospective patient sign an affidavit noting that he was honorably discharged, and then treat him.<sup>88</sup> In every case, it seemed, PHS officials were being told to give the benefit of the doubt to ex-service members, but the BWRI offered little assurance that the government would compensate them or their institutions in a timely fashion for services rendered.

BWRI officials reported concerns of their own about their partner organization. For example, they said, many examination reports were returned to headquarters lacking diagnoses entirely, or containing non-descript diagnoses. One bureau representative stated with frustration that the common diagnosis of neurasthenia, which indicated that a patient had symptoms of both nervous exhaustion and epilepsy “does not mean anything to us.” “We want to know how many attacks the man is having, what kind, whether day or night. ... we want a picture of the epileptic. It does not take more than a page of the examination... we want a picture of the man’s mal-adjustment.”<sup>89</sup> In addition, BWRI staff requested that PHS officials be timelier in their correspondence. Official diagnoses of admitted patients needed to be sent to Washington, D.C. immediately, they argued, so that disability payments could be duly adjusted.<sup>90</sup>

*“We will go to Hell first”: Debating the utility of Soldiers’ Homes*

One week after the conference, BWRI and PHS officials discussed particulars of veterans’ care at another public forum – a congressional hearing regarding the question of

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<sup>88</sup> "Minutes of a Conference between the Public Health Service and the Bureau of War Risk Insurance", 48-49.

<sup>89</sup> Ibid., 29-30.

<sup>90</sup> Ibid., 36.

whether Soldiers' Homes should be used to care for discharged service members. BWRI officials, anxious to re-locate veterans from hundreds of private contract institutions and concentrate them solely in government-owned hospitals, turned to Soldiers' Homes as prospective sites of care. But the idea was controversial. Unlike PHS hospitals, Soldiers' Homes were not viewed as medical facilities. Their long-term, elderly residents used the institutions primarily as residences, rather than to seek improvements in their health. Those who might have had health problems were commonly seen as past the point of cure. World War veterans, on the other hand, could still (ideally) pursue recovery, and resume productive lives in the civilian world. Mixing the two patient types was, many felt, ill advised.

In the early 1920s, there were eleven federally funded National Homes for Disabled Volunteer Soldiers located across the country.<sup>91</sup> Most of them were founded in the late nineteenth century after it became clear that private charity could not cover the cost or labor involved in providing for the needs of thousands of Civil War veterans. Due to the age of the institutions, by the post World War I years, many were in poor physical condition. Although some soldiers' homes contained hospitals on their campuses, the main mission of the facilities was to provide an opportunity for elderly veterans to find beds, meals, and the camaraderie of fellow former service members.<sup>92</sup> Because the homes

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<sup>91</sup> Trevor K. Plante, "The National Home for Disabled Volunteer Soldiers," *Prologue Magazine* Spring 2004.

<sup>92</sup> The most comprehensive source on soldiers' homes (which are also briefly discussed in the Introduction of this dissertation) is Patrick J. Kelly, *Creating a National Home: Building the Veterans' Welfare State, 1860-1900* (Cambridge, Mass.: Harvard University, 1997). On daily life and the social atmosphere in soldiers' homes, see James Marten, "Nomads in Blue: Disabled Veterans and Alcohol at the National Home," in *Disabled Veterans in History*, ed. David A. Gerber (Ann Arbor, Michigan: University of Michigan, 2012). Gustavus Weber also offers a concise summary of the history of the institutions. Gustavus Adolphus Weber and Laurence Frederick Schmeckebier, *The Veterans' Administration, Its History, Activities and Organization* (Washington, D.C.: Brookings Institution, 1934), 70-81.

(like PHS hospitals) were government funded, the BWRI could legally place beneficiaries in their available beds; as early as 1919, the bureau began to do just that.

In addition to the federally run institutions, there were more than 40 state-run soldiers' homes.<sup>93</sup> Many of their administrators voiced concerns about admitting veterans of the most recent war, arguing that their facilities were not suitable for such a task. Some were also hesitant to admit World War veterans because they did not wish to work on a contract basis with the Public Health Service.<sup>94</sup> Still, some veterans were placed in the state homes, which BWRI Director Richard G. Cholmeley-Jones argued led to "considerable complaint, because a great many of (them) are not modern in their methods." By way of explanation, Cholmeley-Jones noted, "they are not real hospitals; they are just homes."<sup>95</sup>

It was not just state institutions that garnered "considerable complaint." Robert Jones, a World War veteran with tuberculosis who was being treated at the federally sponsored Old Soldiers' Home in Togus, Maine, reported that conditions there were highly unsatisfactory. Recently discharged soldiers were housed alongside veterans of the Civil and Spanish-American Wars, Jones said: "Not only is there no segregation of men according to ages, neither is there any according to the condition of patients." The hospital surgeon, he added, "frankly admits that he knows nothing about tuberculosis..." Not to mention the fact that residents of the home were offered a steady diet of "steak and

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<sup>93</sup> On the number of soldiers' homes in existence during and after World War I, see: Plante, "The National Home for Disabled Volunteer Soldiers."

<sup>94</sup> "Analysis of Replies of Various Governors of States Relative to Use of State Soldiers' Homes by World War Veterans", Undated, but likely composed in 1922. Records of Collaborating Boards and Committees, Board of Consultants on Hospitalization, General Correspondence and related records, 1921-23, Record Group 121, Box 12, Entry 164, National Archives and Records Administration, College Park, Maryland.

<sup>95</sup> Hearings before the Subcommittee of the Committee on Appropriations, United States Senate, H.R. 13870, 16-17.

eggs – not fresh by any means – milk and potatoes, seven days a week,” which Jones noted was “monotonous and insufficient.” The home’s lavatories were “not kept clean,” he said, and it was “no unusual sight to frighten away all species of water bugs before we wash or take a bath.” Because of the conditions, Jones said, he had recently lost weight and “suffered from colds and chest pains.”<sup>96</sup> In July 1919, BWRI Chief Medical Advisor, William C. Rucker, acknowledged that Jones’ sentiments were hardly unique. World War veterans, Rucker noted, generally deplored being treated in soldiers’ homes.<sup>97</sup>

Over time, however, the priority of ensuring that all veterans be housed in government run facilities as opposed to private contract institutions took precedence. At House hearings in April 1920, bureaucrats and congressional representatives discussed whether it was feasible to make better use of thousands of empty beds in federally funded soldiers’ homes across the country.

According to the BWRI’s R.G. Cholmeley-Jones, it was perfectly legal to send Bureau patients to such facilities; his agency simply had to verify that the “old soldiers’ homes, in fact, were able to care for them.” Cholmeley-Jones also believed that the care of all ex-service members – including those of previous wars – should be overseen by one agency, namely the Public Health Service. “... It would be a mistake to divide the

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<sup>96</sup> Robert Jones, "Letter from Robert Jones to Dr. Foltz, Medical Division, Bureau of War Risk Insurance" September 3, 1919. Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans' Bureau, 1917-1923, Record Group 90, Box 6, NC-34, Entry 23, National Archives and Records Administration, College Park, Maryland.

<sup>97</sup> "Letter from William C. Rucker to the Public Health Service Hospital Board", July 28, 1919. Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans' Bureau, 1917-1923, Record Group 90, Box 10, Folder: War Risk 1919-1920, NC-34, Entry 23, National Archives and Records Administration, College Park, Maryland.

authority in the handling of the patients of the World War,” he claimed. “I think the experience we have all had is sufficient to make that point very clear in our minds.”<sup>98</sup>

Anxious to stave off complaints from constituents, and the critique that “we are doing nothing to help the boys who are so much in need of help,” members of Congress focused more on immediate solutions than the larger issue of jurisdiction. Why couldn’t administrators “cut the red tape” and get “beds for those boys right away”? Legislators argued that the approximately 8,000 beds available at Soldiers’ Homes should be put to use for recent veterans, and that new veterans could be sent to the homes, but be kept “segregated” from veterans of previous wars (as former serviceman Robert Jones implied they should be). Cholmeley-Jones backed the idea. Previous tenants of the homes could be requested to move to alternative buildings or different facilities, he suggested, so that younger veterans could be treated and housed together.<sup>99</sup>

Congressman Frank Clark (D-FL) saw the irony in placing one group of ex-servicemen above another. “I would be loath to fire (veterans of previous wars) out and put them anywhere else that might be available for them,” he said. Instead of focusing on the politically expedient goal of providing a certain standard of facilities for the newest veterans, Clark brought up the grander ideal of veterans’ rights. “Has any investigation been made to ascertain their wishes in the matter? Would the old soldiers be willing to be segregated in different parts of the homes?”<sup>100</sup>

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<sup>98</sup> Hearings before the Committee on Public Buildings and Grounds, House of Representatives, on Additional Hospital Facilities for Discharged Soldiers, Sailors, Marines, and Army and Navy Nurses, H. Doc. No. 481, Sixty-Sixth Congress, Second Session, (Washington, D.C.: Government Printing Office, April 26, 1920), 6.

<sup>99</sup> Ibid., 11-13.

<sup>100</sup> Ibid., 13-14.

PHS Surgeon General Hugh S. Cumming also had reservations about the plan to separate World War veterans from others, and brought up a host of prospective logistical challenges. A great number of World War veterans seeking institutional care were victims of psychoneurosis or tuberculosis, he pointed out, noting that such patients “should not be indiscriminately thrown in among well people.” Furthermore, he said, surgical patients of the most recent war required more space and personnel than was typically allotted for soldiers’ home residents. Therefore, according to Cumming, the estimate that there was space for approximately 10,000 BWRI patients in just as many soldiers’ home beds was somewhat optimistic. Unlike most tenants of the homes, who had “nothing particularly the matter,” but needed “to be looked over to a certain extent,” World War veterans “have to have the best possible treatment,” he said. Veterans of the Civil and Spanish-American Wars, Cumming implied, were beyond rehabilitation, while their younger counterparts could still benefit from modern medicine.<sup>101</sup> Such statements revealed that the problem of providing medical care for World War veterans was seen as especially complicated and unique. Existing facilities and agencies, authorities suggested, would not suffice in the short- or the long-term.

In spite of the concerns of Cumming and others, and complaints from veterans like Robert Jones, the BWRI continued to make use of beds in soldiers’ homes in the early 1920s, bringing about more dissatisfaction from disgruntled former service members. When the BWRI attempted to move World War veterans from various Massachusetts hospitals to the Home for Disabled Volunteer Soldiers at Togus, Maine, for example, the patients loudly protested, gaining support and publicity for their cause

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<sup>101</sup> Ibid., 15-16.

from the Massachusetts American Legion. Standing by his decision to re-locate the men, R.G. Cholmeley-Jones explained that there was a shortage of hospital beds for veterans in the state. The move was part of a larger plan to concentrate former service members solely in government-owned hospitals, he said, rather than keeping them scattered in more than 1,000 private contract institutions nationwide. The larger intent, Cholmeley-Jones noted, was to ““improve the hospitalization program”” and ““prevent a chaotic condition in the future.””<sup>102</sup> The situation escalated when more than 90 patients scheduled to be transferred to Togus from a tuberculosis sanitarium in Rutland, Massachusetts circulated a petition protesting the move. In Maine, they said, they would be far from family, exposed to potentially harmful sea air, and given inferior food. “We will go to Hell first,” said George A. Bryant, a representative of the Rutland men. “We don’t propose to go off to some spot to die just to suit them.”<sup>103</sup>

An American Legion representative and lawyer, Col. Edward L. Logan, served as a spokesman for patients from Rutland and other Massachusetts contract institutions. Their publicity efforts quickly bore fruit. Merely one day after Cholmeley-Jones argued that the soldiers had to be re-located to “prevent a chaotic condition,” a Public Health Service representative told Logan, “as far as he was concerned the order of transfer... was rescinded.”<sup>104</sup> Within a few days, Massachusetts Legion representatives had met with Cholmeley-Jones, who provided them with a list of all BWRI patients under treatment in Massachusetts with the weighty request that the American Legion “review, with every

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<sup>102</sup> Charles S. Groves, "Tells Government War Risk Program: Jones Explains Transfer of Disabled Men," *Boston Daily Globe* July 30, 1920.

<sup>103</sup> "Clash over Order to Shift Soldiers," *Boston Daily Globe* July 31, 1920.

<sup>104</sup> Ibid.

exactness, the case of each disabled soldier, sailor and marine now receiving treatment in a hospital or sanitarium in the state of Massachusetts.” If, after conferring with the patient and his doctor, the Legion found that “it is not to the best interest of the patient that he be moved,” Cholmeley-Jones suggested that the organization “so advise the District Supervisor of the United States Public Health Service...”<sup>105</sup>

However unrealistic Cholmeley-Jones’ request was, here was governmental sidestepping in the extreme, and evidence of the hopelessness of the situation at hand. Not only was the BWRI handing over administrative responsibilities to an advocacy organization, it was also actively avoiding conceiving of or putting in place a viable solution to the immediate problem. Clearly, this was not a model that could be followed for an indefinite period, or nationwide.

*P.L. 246, debates regarding “shirks and slackers”, and intensifying governmental in-fighting*

The situation surrounding veteran transfers to the National Soldiers’ Home in Togus, Maine did not bode well for the potential of Public Law 246, passed on June 5, 1920. The legislation allocated \$46 million to the BWRI, to be used for compensation of staff and a variety of beneficiary-related expenses, including medical examinations and “medical, surgical, and hospital services.” Some of that money was to be “allotted from time to time” to agencies providing hospital care, including the Board of Managers of the National Homes for Disabled Volunteer Soldiers, the War and Navy Department, and the Public Health Service.<sup>106</sup> The law

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<sup>105</sup> "Logan to Pass Upon Transfers," *Boston Daily Globe* August 3, 1920.

<sup>106</sup> An Act Making Appropriations for Sundry Civil Expenses of the Government for the Fiscal Year Ending June 30, 1921, and for Other Purposes, Public Law 246, H.R. 13870, 41 Stat. 874, Sixty-Sixth Congress, Second Session, (Washington, D.C.: Government Printing Office, June 5, 1920), 881.



provided mainly for the improvement of existing medical facilities, rather than the building of new ones. It offered millions of dollars for veterans' care, but did nothing to alleviate bureaucratic strife.

Although hard-fought and seen as a major victory by veterans' organizations, PL 246 met with hostility from Public Health Service officials who loathed the idea of having to seek money, and by extension, being subservient to the BWRI. "You give us the hospitals, PHS Assistant Surgeon General Charles H. Lavinder told members of Congress, "but you do not give us any money to operate them." PHS officials explained that in the current situation, they were "laboring under unusual conditions," in that they had to request a specific amount of money from the BWRI to fund the improvement of buildings at each specific institution that necessitated work. If it turned out there was too little money once a project was underway, the PHS had to plead its case again. "We have no money during the coming year for making alterations or additions to any hospital that may be turned over to us in the future" said PHS Assistant Surgeon General William G. Stimpson, referring to institutions that may be passed on by the army or National Soldiers' Home Board of Managers.<sup>107</sup> As Stimpson's colleague, Charles Lavinder, put it, "We have a big machine," but unless the Secretary of the Treasury was given control of funding, as opposed to the BWRI, "we would have no guarantee of necessary funds for operation and no basis upon which to formulate plans."<sup>108</sup> PHS officials approved of devoting more money to medical care for ex-soldiers, but they disapproved of the BWRI controlling it. They argued that funding should be allocated not to the BWRI, but to the office of the Secretary of the

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<sup>107</sup> Hearing before the Subcommittee of the House Committee on Appropriations, United States Senate, Part 2, H.R. 13820, Sixty-Sixth Congress, Second Session, (Washington, D.C.: Government Printing Office, March 12, 1920), 2546-52.

<sup>108</sup> Hearings before the Subcommittee of the Committee on Appropriations, United States Senate, H.R. 13870, 86-93.

Treasury, which oversaw both the BWRI and PHS.<sup>109</sup> Cholmeley-Jones, of the BWRI, countered that since “under the War Risk Insurance Act, these men are declared to be patients of the Bureau of War Risk Insurance and we deal with these men and their dependents in several respects,” the BWRI should have control of money.<sup>110</sup>

During debates regarding the passage of Public Law 246, some senators questioned the very idea of earmarking more public funds for the hospitalization of veterans, many of whom they felt were not worthy of such a privilege. James W. Good (R-IA) was disturbed to learn that 22,000 ex-soldiers were classifiable as “feeble-minded,” meaning, according to William C. Rucker of the PHS, they had “never developed to the point of maturity.” Why, Good wanted to know, were they accepted into the military in the first place? Rucker explained that entrance exams were brief, so not all cases were detectable. Plus, he pointed out, “a man can ‘peel spuds’ even if he only has the mentality of a 10-year-old child.” Good was aghast. “Here is a person who never did develop mentally, was always feeble-minded, and his service in the war did not make him any more feeble-minded than before, and he is just as healthy and has as much mentality now as he had then,” he said. “Why does the government owe that man, because of his service in the war, any greater obligation than any other man who was not injured either mentally or physically because of his service?” Rucker declined to take up the question on an ideological level but instead, made a legal argument. By virtue of previous legislation, he said, it was assumed “that the men who are accepted shall be accepted as of sound condition.” And it was mandated that the government would provide necessary medical services for all those who

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<sup>109</sup> Ibid., 89-93.

<sup>110</sup> Hearing before the Subcommittee of the Committee on Appropriations, United States Senate, Part 1, H.R. 13870, Sixty-Sixth Congress, Second Session, (Washington, D.C.: Government Printing Office, February 16, 1920), 251-54.

served.<sup>111</sup> In a sense, Rucker was saying, the system was inherently flawed, but the government was legally obliged to ensure that it remain intact and functional.

Francis E. Warren (R-WY) focused less on the question of pre-existing health maladies than on whether individuals were consciously besting the system. Were veterans, he wondered, remaining in hospitals or on the disability rolls not because they had legitimate needs, but simply to garner large monthly payments? Warren was disturbed to learn that, before discharge from the army, soldiers were earning \$30 per month while receiving hospital care, but that they could get as much as \$100 or more once they were under treatment as BWRI patients. He worried that Congress was “setting up a premium upon shirks and slackers by paying them a good deal more than they can get in wages.” At some point, he said, “somebody somewhere has to say ‘No’ and stop the flood leading to indolence...”<sup>112</sup> Concerns voiced by Good and Warren were typical of those who questioned the veracity of similar legislation granting rights and services to veterans throughout the early 1920s.

Advocates of Public Law 246 overpowered the opposition, in part by arguing that Congress had an obligation to approve the request for funding mainly because of guarantees contained in the 1917 War Risk Insurance Act regarding war-related illnesses and injuries. Certifications of disability were increasing at a rate of 1,200 per month, according to a congressional report regarding new hospital facilities for war veterans: “We have assumed this liability. Under the law, we are obliged to meet it... we must make adequate provision.” In fact, the report’s authors favored the passage of Public Law 246, not least of all because it allocated \$46 million, as opposed to the full \$85 million originally requested by William C. Rucker and Rupert Blue in House Document 481 of December 1919. In this way, PL 246 would actually allow Congress to

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<sup>111</sup> Ibid., 241-50.

<sup>112</sup> Hearings before the Subcommittee of the Committee on Appropriations, United States Senate, H.R. 13870, 86.

“avoid an expenditure,” though there was a distinct possibility that “additional hospitals may be required at a later date.”<sup>113</sup>

In spite of funding increases, systemic problems brought up in Congress and through inter-organizational conversations continued to plague the PHS and the BWRI throughout 1920 and 1921. Even after the allocation of \$46 million to the latter organization in June 1920, governmental agencies faced administrative difficulties, problems coordinating standards of care and discipline, and the reality of inadequate facilities. By 1921, PHS and BWRI officials openly exchanged accusations of ineptitude. The question at hand had evolved from whether the system as it stood was working, to who was to blame for, and what was to be done about its myriad dysfunctions.

In mid-1920, PHS Surgeon General Cumming made it clear to BWRI officials that he was frustrated with his organization’s lack of autonomy. The PHS, he explained, had put into operation various hospitals “in haste” in 1919, and “with a full realization that many of the hospitals opened were not satisfactory for the purpose.” Still, the organization was fulfilling its responsibility to answer an “urgent need... pending the adoption of some program which would more adequately and more permanently meet the needs of the situation.” But recently, Cumming pointed out, instead of honoring requests from the PHS for money to build new facilities, Congress had appropriated \$46 million to the BWRI, which had chosen to allocate resources to transfer ex-service members to national soldiers’ homes as opposed to building permanent facilities that could be used for long-term needs. Now that the BWRI was in control of the money, Cumming asked for some definitive answers: should his organization continue to acquire hospital

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<sup>113</sup> Hospital for Bureau of War Risk Insurance, House Report No. 1098, to Accompany H.R. 14315, 3.

facilities? Should the PHS continue to operate facilities it deemed inadequate, simply because they were in regions that contained no other institutional options for ex-service members?<sup>114</sup>

A later memo described the “legal position” of the PHS in relation to veterans’ care as “very unsatisfactory,” mainly because jurisdiction over funding had been placed entirely in the hands of the Director of the BWRI.<sup>115</sup> Thus, the PHS was in the awkward position of requesting any and all necessary money to care for soldiers – including salary increases for its doctors – from another government agency. In March 1920, Cumming went public with his dissatisfaction with such an arrangement. Explaining that his agency was caring for 12,000 discharged soldiers, he noted that ten percent of officers had already resigned their posts, and the PHS was unable to attract medical personnel of any grade – specialists, surgeons, or otherwise – because “the pay offers no inducements.”<sup>116</sup>

It was not just the PHS that complained to the BWRI about lack of payment. In February 1920, BWRI Chief Medical Advisor William C. Rucker requested that the PHS “expedite payment” to a state hospital in Fulton, Missouri, where ex-service members received treatment. “This institution is making vigorous protests on account of delays in

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<sup>114</sup> "Letter from H.S. Cumming, Surgeon General, to the Director of the Bureau of War Risk Insurance", July 16, 1920. Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans Bureau, 1917-1923, Record Group 90, Box 8, NC-34, Entry 23, National Archives and Records Administration, College park, Maryland.

<sup>115</sup> "Memorandum of the Public Health Service in Relation to Its Work in the Medical Care and Treatment of Ex-Service Men and Women", September 23, 1920. Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans Bureau, 1917-1923, Record Group 90, Box 11, NC-34, Entry 23, National Archives and Records Administration, College Park, Maryland.

<sup>116</sup> "Low Pay Hurts Health Service; Doctors Inadequate to Care for 12,000 Soldiers at U.S. Hospitals," *The Washington Post* March 17, 1920.

payment of their bills,” Rucker reported to PHS officers.<sup>117</sup> The Fulton institution, one of more than one thousand private hospitals contracted to work with the PHS on providing care to BWRI beneficiaries, was compensated for its services by the PHS, which, in turn, was reimbursed by the BWRI. The idea of having medical providers two steps removed from funding sources in two different government agencies was simply untenable. It left both BWRI and PHS officials feeling as though they had little control.

Government agencies encountered not only logistical problems related to payments, but also a lack of clarity regarding authority over treatment. In order for a patient to be transferred or discharged from a hospital, for example, the institution wired a request to the PHS Surgeon General’s office. From there, a telegram was sent to the BWRI advising how to proceed with the case. Then, BWRI headquarters replied to the PHS office in Washington, DC, which finally passed on word to the hospital. The entire process could take a week or more, often leaving both patients and doctors feeling frustrated. Meanwhile, PHS and BWRI officials in Washington, DC and elsewhere exchanged accusations that unnecessary delays were occurring in fulfilling requests for treatment, transfers, and disability payments.<sup>118</sup>

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<sup>117</sup> "Letter from W.C. Rucker, Chief Medical Advisor, to U.S. Public Health Service", February 7, 1920. Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans Bureau, 1917-1923, Record Group 90, Box 10, NC-34, Entry 23, Folder: War Risk: 1919-1920, National Archives and Records Administration, College Park, Maryland.

<sup>118</sup> For samples of timelines of various patients’ transfers in the spring of 1920, see "Memorandum for Dr. Lavinder, "Delay Incident to the Transfer of Patients through War Risk Bureau", June 18, 1920. Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans' Bureau, 1917-23, Record Group 90, Box 6, NC-34, Entry 23, National Archives and Records Administration, College Park, Maryland. Regarding the BWRI’s accusations that the PHS failed to pass on patients’ claims for compensation in a timely manner, see: "Letter from W.C. Rucker, Assistant Surgeon General, U.S.P.H.S., Chief Medical Advisor, B.W.R.I., to Surgeon General, U.S.P.H.S.", April 21, 1920. Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans' Bureau, 1917-23, Record Group 90, Box 8, NC-34, Entry 23, National Archives and Records Administration, College Park, Maryland.

The necessity for a long string of communication surrounding each patient brought about shortfalls in services. In July 1920, William C. Rucker, of the BWRI, requested that Surgeon General Cumming advise PHS district offices to get in touch with army and navy hospital commanding officers in the event that more than ten veteran-patients were to be transferred to their respective institutions at one time – at least a few days prior to the transfer, if possible. Cumming replied that he agreed that such notification was necessary, but argued that it should emanate from the office of the Director of the BWRI.<sup>119</sup> Officials at both government agencies, then, acknowledged a lack of coordination and communication, but with their jurisdictions ambiguously defined, they were reluctant to assume the responsibility of acting to fix problems.

In addition to reports about a lack of coordination and communication, there were increasing complaints by 1921 that some institutions where ex-service members received care were inadequate. In fact, no one – from patients and government personnel (including representatives of the PHS and BWRI) to doctors and emerging veterans' groups – seemed satisfied with available facilities. Even though the PHS was charged with inspecting private facilities before approving their use as contract institutions and rejected many, some “inadequate” sanatoria and hospitals were approved to provide care.<sup>120</sup> In January 1921, Walter L. Treadway, Chief of the Neuro-psychiatric Division of

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<sup>119</sup> "Letter from W.C. Rucker, Assistant Surgeon General, U.S.P.H.S., to Surgeon General, U.S.P.H.S.", July 26, 1920. Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans' Bureau, 1917-23, Record Group 90, Box 6, NC-34, Entry 23, National Archives and Records Administration, College Park, Maryland.

<sup>120</sup> There are various examples of the PHS rejecting institutions as contract facilities, especially for use by psychiatric patients. A sanitarium in St. Joseph, Missouri, for example, was said to be “not well equipped and not up to the standard required for the care and treatment of neuro-psychiatric beneficiaries of the Public Health Service.” "Letter from Office of the Surgeon General, U.S.P.H.S., Section of Neuropsychiatry, to Assistant Director, Medical Division, B.W.R.I. Re. C.R. Woodson Sanitarium", February 12, 1921. Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans Bureau, 1917-1923, Record Group 90, Box 10, NC-

the PHS, requested that the BWRI authorize that beneficiaries be “immediately removed” from the Sunnybrook Farm Sanatorium, a PHS contract institution in Illinois.

Sunnybrook Farm, he said, was “poorly administered and poorly equipped.”<sup>121</sup>

Throughout early 1921, Treadway wrote similar letters about other contract institutions:

the Massillon State Hospital in Ohio, he said, was “not sufficiently staffed with medical officers, nurses, and attendants to accord proper treatment to neuro-psychiatric

beneficiaries...”<sup>122</sup> In June 1921, Treadway pointed out that an Augusta, Georgia facility

lacked hydro- and electro-therapy equipment, and expressed some doubt that a doctor

there was “a bona fide graduate in medicine and duly licensed to practice his

profession.”<sup>123</sup>

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34, Entry 23, Folder: BWRI carbons Jan. 1st to Mar. 31st, 1921 National Archives and Records Administration, College Park, Maryland. Treadway also rejected a contract for the Highland Hospital in North Carolina; although it was a “high-class private institution,” he said, “the Superintendent... is not in good standing with the local medical profession.” “Letter from W.L. Treadway, Chief Neuropsychiatric Section, U.S.P.H.S., to Assistant Director in Charge of Medical Division, B.W.R.I.", February 8, 1921. Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans' Bureau, 1917-23, Record Group 90, Box 10, NC-34, Entry 23, Folder: BWRI carbons Jan. 1st to Mar. 31st, 1921 National Archives and Records Administration, College Park, Maryland.

<sup>121</sup> “Letter from W.L. Treadway, Chief, Neuropsychiatric Section, U.S.P.H.S., to Assistant Director, Medical Division, B.W.R.I.", January 19, 1921. Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans' Bureau, 1917-23, Record Group 90, Box 10, NC-34, Entry 23, Folder: BWRI carbons Jan. 1st to Mar. 31st, 1921 National Archives and Records Administration, College Park, Maryland.

<sup>122</sup> “Letter from Office of the Surgeon General, U.S.P.H.S., Section of Neuropsychiatry, to Assistant Director, Medical Division, B.W.R.I. Re. Massillon State Hospital", February 12, 1921. Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans Bureau, 1917-1923, Record Group 90, Box 10, NC-34, Entry 23, Folder: BWRI carbons Jan. 1st to Mar. 31st, 1921 National Archives and Records Administration, College Park, Maryland.

<sup>123</sup> “Letter from W.L. Treadway, Chief, Neuropsychiatric Section, U.S.P.H.S., to Assistant Director, Medical Division, B.W.R.I. Re. Augusta Georgia", June 22, 1921. Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans' Bureau, 1917-23, Record Group 90, Box 10, NC-34, Entry 23, Folder: BWRI carbons Jan. 1st to Mar. 31st, 1921 National Archives and Records Administration, College Park, Maryland. By December 1921, as the PHS and BWRI handed over jurisdiction to the Veterans' Bureau, standards had risen, and the American Legion was demanding that Neuro-Psychiatric specialists be stationed at six PHS hospitals treating “mental cases” in California and Arizona. “Letter from Claude J. Harris, Acting Director, National Service Division, American Legion, to C.R. Forbes, U.S.V.B.", December 12, 1921. Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans' Bureau, 1917-1923, Record Group 90, Box 9, National Archives and Records Administration, College Park, Maryland.



Although BWRI officials attempted to ensure that institutions serving the majority of Bureau beneficiaries were of a certain caliber, standards were decidedly lower when it came to providing for patients of color. In February 1921, Treadway wrote to the Medical Division of the BWRI regarding the Central State Hospital in Nashville, Tennessee. The facility was “not sufficiently equipped or staffed to be considered desirable as a place for the treatment of beneficiaries of the Public Health Service...” he said, presumably referring only to white beneficiaries. He recommended that the hospital might be suitable for the “care of all colored insane residents of District No. 5 and 6...” He noted that “certain principles in respect to personnel” should be observed, including the provision of a minimum number of doctors, nurses, orderlies, and occupational therapists.<sup>124</sup> The government was willing to fulfill its legal responsibilities to all ex-service members, but with varying degrees of generosity and abundance.<sup>125</sup>

Whatever semblance of a system existed, it seemed, was spinning out of control. As BWRI Director Cholmeley-Jones put it in late 1920, the hospitalization situation was “manifestly unsatisfactory to the disabled ex-service men and women and to the government alike.” Federal agencies had not had time to acquire “adequate hospital

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<sup>124</sup> "Letter from W.L. Treadway, Chief Neuropsychiatric Section, U.S.P.H.S., to Assistant Director in Charge of Medical Division, B.W.R.I. Re. Central State Hospital, Nashville, Tennessee", February 14, 1921. Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans' Bureau, 1917-23, Record Group 90, Box 10, NC-34, Entry 23, Folder: BWRI carbons Jan. 1st to Mar. 31st, 1921 National Archives and Records Administration, College Park, Maryland.

<sup>125</sup> Apparently, some institutions did not pass muster as being suitable for any ex-service members, including people of color. Soon after he recommended that the Central Tennessee State Hospital be used for African Americans but not for whites, Treadway wrote to the BWRI recommending that “it would not be advisable to utilize” the Crownsville State Hospital in Crownsville, Maryland “as a place for the treatment of colored beneficiaries of the Public Health Service...” No explanation for the decision was offered. "Letter from W.L. Treadway, Chief Neuropsychiatric Section, U.S.P.H.S., to Assistant Director in Charge of Medical Division, B.W.R.I. Re. Crownsville State Hospital, Crownsville, Maryland", February 12, 1921. Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans' Bureau, 1917-23, Record Group 90, Box 10, NC-34, Entry 23, Folder: BWRI carbons Jan. 1st to Mar. 31st, 1921 National Archives and Records Administration, College Park, Maryland.

facilities,” he said, and it had thus become necessary to conceive of a re-vamped plan to provide medical care to veterans.<sup>126</sup>

By September 1920, PHS and BWRI officials moved from suggesting that their partner organizations were bureaucratically impotent, to accusing their representatives of active malfeasance. In a letter that he asked be considered “confidential in the extreme,” PHS Senior Surgeon William S. Terriberry explained to a colleague in the field that he had obtained a copy of a letter from a BWRI official requesting that the Red Cross visit PHS facilities and “make certain investigations as to the satisfaction of the patients with their treatment,” including their feelings about their doctors, food, and living conditions. Red Cross personnel, Terriberry reported, replied that they were unwilling to use their organization to “spy” on the PHS. A frustrated PHS officer shared news of the accusations with a Boston reporter, who duly noted in a newspaper article that the organizations were sparring, Terriberry said. Now, Cholmeley-Jones of the BWRI had complained to the Secretary of the Treasury that PHS officers were “engaged in political propaganda.”<sup>127</sup> The tension was evident on the ground level, too, according to a BWRI inspector who visited a Public Health Service hospital in Louisville, Kentucky. There, the bureau representative was greeted by a commanding officer who would not allow him to distribute questionnaires to patients in spite of his reassurances that he was “not sent for

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<sup>126</sup> "Peak Attained in War Risk Men under Army Care," *The Come-Back* September 18, 1920.

<sup>127</sup> "Letter from William S. Terriberry, Senior Surgeon, U.S.P.H.S., to Surgeon Hugh De Valin, Supervisor, District #13, U.S.P.H.S.", September 18, 1920. Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans Bureau, 1917-1923, Record Group 90, Box 8, NC-34, Entry 23, National Archives and Records Administration, College Park, Maryland.

the purpose of inviting criticisms... but merely for the purpose of cooperating with the U.S.P.H.S... to create a pleasing impression with the ex-service men themselves...”<sup>128</sup>

Terriberry was correct that the BWRI had asked Red Cross officials to visit PHS facilities. In July 1920, BWRI Representative J.H. Widerman wrote to a Red Cross worker in Camp Sevier, South Carolina requesting a “confidential report” regarding how patients were being “treated by our... surgeons... with what degree of sympathy” their complaints were being received, and, in general, “how they are being cared for.”<sup>129</sup> Approximately one month later, Grover F. Sexton, the head of the BWRI’s Investigation Field Services, took it a step further, and sent a memorandum to his agency’s representatives throughout the United States, requesting “a general clean-up of all delayed cases...” He asked that BWRI employees visit PHS hospitals, “preferably in

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<sup>128</sup> "Letter from William A. Robinson, Special Representative, Louisville, Kentucky, B.W.R.I., to Major Grover Sexton, Chief, Investigative Field Service", September 20, 1920. Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans Bureau, 1917-1923, Record Group 90, Box 8, NC-34, Entry 23, National Archives and Records Administration, College Park, Maryland.

<sup>129</sup> "Letter from J.H. Widerman, Representative, B.W.R.I., to Ruth Symonds, American Red Cross, Camp Sevier, S.C.", July 19, 1920. Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans Bureau, 1917-1923, Record Group 90, Box 8, NC-34, Entry 23, National Archives and Records Administration, College Park, Maryland. During the previous summer, the BWRI had requested that various improvements be made to the Greenville institution, and the PHS had fulfilled the request: plans were made to replace window screens, social workers were hired, proposals were being accepted for the installation of a refrigeration unit, cars, and china were supplied to the hospital. Widerman’s request for a confidential report suggests that the improvements had not been completed to the satisfaction of patients, or the BWRI. "Letter from Assistant Surgeon General to Chief Medical Advisor, B.W.R.I.", June 28, 1919. Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans Bureau, 1917-1923, Record Group 90, Box 7, NC-34, Entry 23, National Archives and Records Administration, College Park, Maryland. In September 1920, a PHS Senior Surgeon on duty at the South Carolina hospital wrote to the Director of the BWRI to report that he had “conferred with... the entire staff of workers” there, and none of them had any complaints about the institution. "Letter from C.C. Thurber, Hospital Director, to Col. Ja,Es E. Dedman, U.S.P.H.S. Service Hospital #26, Greenville, South Carolina", September 7, 1920. Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans Bureau, 1917-1923, Record Group 90, Box 8, NC-34, Entry 23, National Archives and Records Administration, College Park, Maryland. By 1921, the Greenville hospital was one of a few scattered across the country that the PHS reported was full to capacity or overcrowded. "Letter from Surgeon General H.S. Cumming, to Director, B.W.R.I., Re. Service Hospitals Practically Filled", June 4, 1921. Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans Bureau, 1917-1923, Record Group 90, Box 10, Folder: War Risk, Jan. 1-June 30, 1921 National Archives and Records Administration, College Park, Maryland.

company with representatives of the American Legion or the American Red Cross,” to assess patients’ opinions “of how service is being rendered,” and physicians’ thoughts on patients’ conditions. “The Director desires that he shall be able to say that a representative of the Bureau has called on every man in every hospital, ready to render every service possible,” Sexton reported. He asked BWRI representatives to “search” PHS office files “to see if there are any delayed cases,” but advised them to do so “in conjunction with” PHS officers, and noted that there was “to be nothing of criticism... only a most energetic effort to serve every disabled man and woman that we can reach.”<sup>130</sup>

The heads of the BWRI and the PHS each backed the accounts of their representatives. Cholmeley-Jones wrote directly to Surgeon General Cumming asking that he advise local hospital commanding officers to allow BWRI representatives to question patients. The visits were meant to serve less as “inspections” than as a means to make the work of the two organizations “more effective.”<sup>131</sup> Cumming demurred: “the investigations,” he believed, were meant to “discredit the work of the Public Health Service.” Sexton’s original letter regarding a “clean-up” campaign was not so innocent,

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<sup>130</sup> "Letter from Grover F. Sexton, Investigative Field Service, to Special Representative, Investigation Field Service, B.W.R.I.", August 25, 1920. Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans Bureau, 1917-1923, Record Group 90, Box 8, NC-34, Entry 23, National Archives and Records Administration, College Park, Maryland.

<sup>131</sup> "Letter from R.G. Cholmeley-Jone, Director, B.W.R.I., to Surgeon General Cumming, P.H.S.", October 23, 1920. Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans Bureau, 1917-1923, Record Group 90, Box 8, NC-34, Entry 23, National Archives and Records Administration, College Park, Maryland.

he argued, and had prompted BWRI field representatives to “find something of which a complaint could be made.”<sup>132</sup>

The correspondence between the two government agencies in the fall of 1920 signaled the dawn of a new era in veterans’ medical care, wherein the impressions and opinions of ex-service members held renewed import. In each of their letters regarding the investigation and standards of hospitals, Sexton and Terriberry hinted at the impetus for the change: the emergence of a new and powerful organization called the American Legion. According to Terriberry, the PHS and BWRI should sort out their problems before the annual meeting of the Legion, or else damaging charges of infighting were “apt to be thrown about.”<sup>133</sup>

Eager to uphold the congressional mandates set out for them with limited resources, and without being accused of neglect, disparate government agencies were unable to maintain appearances of harmony and success once veterans’ groups arrived on the scene, raising demands and expectations. Throughout 1920 and 1921, advocacy organizations helped bring to a close the era of PHS-BWRI joint authority over veterans’ medical care, and played an integral role in the successful fight for the August 1921 establishment of the Veterans’ Bureau.

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<sup>132</sup> "Letter from H.S. Cumming, Surgeon General, P.H.S., to Director, B.W.R.I.", October 30, 1920. Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans Bureau, 1917-1923, Record Group 90, Box 8, NC-34, Entry 23, National Archives and Records Administration, College Park, Maryland.

<sup>133</sup> "Letter from William S. Terriberry, Senior Surgeon, U.S.P.H.S., to Surgeon Hugh De Valin, Supervisor, District #13, U.S.P.H.S.".

## Conclusion

In March 1919, when the Public Health Service officially took over the medical care of all BWRI beneficiaries, it was treating 1,500 Bureau of War Risk Insurance patients. By March 1921, that number had increased to 26,000 patients, and the flow showed now signs of ebbing; an average of 2,000 BWRI beneficiaries were being admitted to PHS hospitals each week, while only 1,700 were being discharged, leaving a net increase of approximately 1,200 patients per month. All in all, by the summer of 1921, the PHS had overseen treatment for 150,000 BWRI patients in a multitude of public and private medical facilities.<sup>134</sup>

Around that time, PHS Surgeon General Cumming took to defending his agency against complaints about its post-war performance. His sentiments regarding the organization's ability to rise to a challenge and perform well under pressure echoed those expressed by Army Medical Department officials earlier in the war effort. Representatives of the PHS, Cumming pointed out, had argued on the congressional floor as early as December 1919 that more facilities and funding were necessary. Their early predictions, he said, which were initially criticized as "pretentious," had, in fact, proven prescient, as demand increased over time. "I know that we have sincerely attempted to render to ex-service men and women the best service possible under the circumstances," Cumming said in July 1921. "I realize that we may have fallen short of our ideals in a great many respects, yet I feel under the circumstances that disabled veterans who have

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<sup>134</sup> Cumming, "The Work of the Public Health Service in the Care of Disabled Veterans of the World War," 6.

come under the care of the Public Health Service have received sympathetic consideration as well as good professional care and treatment.”<sup>135</sup>

Other PHS officials expressed similar perspectives. “There is nothing we can do that will adequately justify the sacrifices which you have made,” Senior PHS Surgeon B.W. Brown, told a gathering of veterans in June 1921. At the close of the war, he noted, “Congress had only one medical organization and that was the PHS. We were well organized for our specific duty, which is to administer the National Health Functions of this country, but we were improperly organized to take care of the disabled men of an army of 4,650,000 soldiers.” Still, Brown maintained, “We did not utter a complaint. We jumped into the breach, and with our 22 hospitals, 700 doctors, we did the best we could do for you.”<sup>136</sup>

Bureaucrats and politicians faced a difficult task as they attempted to decipher how to fulfill responsibilities defined ambiguously by the 1917 War Risk Insurance Act. While they did so, rules and norms seemed to be ever changing. Even as memories of the war faded in the public eye, advocacy groups became more vocal and demanding, and veterans’ expectations of their government evolved. Congressional representatives were torn between enhancing benefits for former service members in the name of fulfilling a

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<sup>135</sup> Ibid.: 10.

<sup>136</sup> “Proceedings of the First National Convention of the Disabled American Veterans of the World War, at the Chamber of Commerce, Detroit, Michigan”, June 28-30, 1921. Proceedings of National Conventions, Copy held by author, Disabled American Veterans National Headquarters, Cold Spring, Kentucky. Robert D. Leigh points out that Cholmeley-Jones, the Director of the BWRI, took a stance similar to that of Cumming and Brown, and defended his organization. Congressional representatives, not bureaucrats, were to blame for dysfunctions in the system, Leigh argues. They had failed to fulfill the requests of experts familiar with the extent of the need for medical care. In April 1922, Senator David Walsh issued a report acknowledging as much, and placing the blame on Congress, not the BWRI or PHS. As Leigh puts it, between 1919 and 1921, government administrators were “the heroes” and Congressional representatives “the villains.” Robert D. Leigh, *Federal Health Administration in the United States* (New York, London: Harper & Bros., 1927), 188-89, 214-15.

righteous obligation, and demonstrating economy by questioning the veracity of claims that more hospital services were necessary. But age-old arguments about the existence of a national responsibility to veterans – especially those who had sacrificed their health while fighting on behalf of their country – were powerful. Savvy veterans' groups were eventually able to gain political support for the establishment of one government agency to oversee all veterans' benefits and medical care, in part, by pointing out how dysfunctional the system was as it stood. Veterans, they argued, had been short-changed, and they deserved better.



## CHAPTER FIVE

### **Civilian-citizens become veteran super-citizens: Interest group advocacy (1919-1921)**

The story of soldiers' and veterans' medical care in the World War I years is, in part, a story about veterans' activism. The advocacy groups of the Great War built on the achievements of their nineteenth century predecessors, who helped ensure the creation of a massive pension system by arguing that ex-soldiers deserved special privileges from their government.<sup>1</sup> But veterans' advocates of the World War I era also capitalized on the widely held view that cash pensions were no longer an ideal form of recompense. They fought not only for monetary payments, but also focused on securing other lasting and extensive rights: among them, special access to jobs, land, and institutions such as hospitals. Advocacy organizations founded following the Great War, including the American Legion (AL) and the Disabled American Veterans (DAV), thus helped shape veterans' policies and benefits for the remainder of the twentieth century.<sup>2</sup> The efforts of the organizations pertaining to medical care for veterans reveal that political change took compromise and, in some cases, contradictory action. In many ways, a study of veterans' activism in this era showcases democracy at its finest. It is a story of poor and middle-class Americans banding together in order to have their demands met by a somewhat resistant government.

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<sup>1</sup> On the soldiers' pension system spawned by the Civil War, see Theda Skocpol, *Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States* (Cambridge, Mass.: Belknap Press of Harvard University Press, 1992).

<sup>2</sup> The Veterans of Foreign Wars, which will be discussed in Chapter Six, was also a powerful advocate throughout the post-war years and twentieth century, though it was founded in the wake of the Spanish-American War. On the VFW, and the long-term influence of post-war veterans' advocacy, see Stephen R. Ortiz, *Beyond the Bonus March and G.I. Bill* (New York, New York: New York University Press, 2010), 16. Recently, scholars have pointed to the post-World War I years as crucial in shaping the future U.S. veterans' welfare state. See the Introduction for an overview of this literature, which includes Kathleen J. Frydl, *The G.I. Bill* (New York, New York: Cambridge University Press, 2009); Glenn C. Altschuler; Stuart M. Blumin, *The G.I. Bill: A New Deal for Veterans* (New York, New York: Oxford University Press, 2009).

But the story isn't as simple as the powerless uniting to demand and receive privileges. Veterans' groups won the fight for access to hospitals and other benefits for their constituents, in part, by cloaking their demands in rhetoric of "100 percent Americanism" and anti-radicalism, and thereby arguing against the notion that *all* citizens were worthy of the same rights. Even as they claimed to accept and welcome black members, for example, officials of the DAV and American Legion denied African American veterans access to the group's conferences, and fought against the integration of both military and veterans' hospitals. This seemingly contradictory stance illuminated intra-organizational divides and disagreements about policies regarding inclusion. On a more general level, it indicated that when it came to putting forth a public image of national veterans' organizations in an era of growing racial and social tensions, the priority of gaining benefits for white, male veterans took precedence over gaining benefits for all veterans.

Although their efforts were steeped in the predominantly anti-egalitarian ideology of the times, advocacy groups founded in the years following the Great War were instrumental in securing long-lasting and extensive rights for former service members. The political victories of the Legion and DAV, among others, helped bring about not only a federal hospital system for veterans, but also the 1944 G.I. Bill, and a flurry of government benefits for ex-service members in the following decades. They also provided a framework upon which women and minority former service members could fight for their own enhanced rights.

The American Legion fought for material benefits for ex-soldiers, motivated not by an anti-government agenda, but instead, by the idea that politically and socially vulnerable veterans had to be convinced that their country was grateful for their efforts. Veterans' groups after World War I were far from politically monolithic; the agendas of the American Legion and DAV were

influenced by larger social circumstances, as well as comparatively smaller organizations.<sup>3</sup> Some ex-service members joined “single-population” groups, which brought together veterans based on disability, such as blindness or deafness; those organizations often attempted to eschew any political stances.<sup>4</sup> There were also plenty of veterans’ groups with a decidedly leftist political ideology. While conservative groups like the American Legion advocated an anti-immigrant, anti-communist, pro-military ideology, these smaller groups embraced socialistic, pro-labor ideals, and were anti-military; they claimed that veterans should fight for material rewards from their government based on the conviction that they had been unjustly exploited and thanklessly discarded by the U.S. Army. Historian Jennifer Keene argues that the multitude of political stances articulated immediately following the war via veterans’ organizations with a variety of ideological backgrounds had been consolidated to a unified political voice by 1922, in part thanks to the government’s active attempts to silence so-called radicals.<sup>5</sup> A unified political voice was also achieved because Legion officials learned that in order to be perceived as more than a right-wing propaganda machine controlled by elites, their organization had to advocate for special privileges, including access to free medical care.<sup>6</sup>

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<sup>3</sup> According to one account, more than 175 veterans’ organizations arose immediately following the war. John Kinder, “Encountering Injury: Modern War and the Problem of the Wounded Soldier” (Ph.D. Dissertation, University of Minnesota, 2007), 256-62.

<sup>4</sup> Gerber argues that disabled veterans joined “mixed organizations,” whose members were both “able-bodied” and disabled (such as the Legion and the DAV); “composite organizations,” which had members who had a variety of disabilities, and “single population organizations,” where they banded together with others who had the same injuries or illnesses. David A. Gerber, “Disabled Veterans, the State, and the Experience of Disability in Western Societies, 1914-1950,” *Journal of Social History* 36.4(2003).

<sup>5</sup> Jennifer D. Keene, *Doughboys, the Great War, and the Remaking of America* (Baltimore: The Johns Hopkins University Press, 2001), 167-73. William Pencak also provides a detailed discussion of the field of veterans’ advocacy by the end of World War I: William Pencak, *For God and Country: The American Legion 1919-1941* (Boston: Northeastern University Press, 1989), 49-52.

<sup>6</sup> Stephen Ward argues that the Legion and VFW were not only right-leaning but also promoted a “narrow, intolerant superpatriotism.” *The War Generation: Veterans of the First World War*, ed. Stephen R. Ward (London: Kennikat Press, 1975). John Kinder takes a more nuanced view, noting that “historians and critics have labored under two

### Interest groups in American politics

The stories of the roots and activities of the American Legion and the DAV in the early 1920s serve as case studies of the intricacies of interest group politics. Scholars have long recognized the importance of interest groups in the machinations of American government, though they have debated whether they foster or deter democracy. Political scientist Jeffrey M. Berry defines interest groups as organizations that aim to influence the government through lobbying (of members of Congress, the general public, or other key groups). They also play several other roles, Berry points out, from educating the public and framing political issues in a certain way, to building specific agendas, and closely monitoring existent government programs.<sup>7</sup>

In 1787, as the U.S. government was taking shape, James Madison noted the potential for people to organize in “factions,” which he defined as citizens “united... by some common impulse of passion, or of interest, adverse to the rights of other citizens, or to the permanent and

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broad, but ultimately distorting, visions of the American Legion’s origins...” Academic historians, he notes, “tend to view the Legion as a dangerous manifestation of post-World War I chauvinism,” while Legion historians and insiders argue that the group’s identity centers on ideals of loyalty and sacrifice. Kinder concludes that the “Legion’s early identity and work – particularly on behalf of disabled veterans – belies neat categorization.” Kinder, “Encountering Injury: Modern War and the Problem of the Wounded Soldier”, 256-62. Robert D. Leigh notes the importance of groups like the American Legion in the battle for the passage of legislation granting benefits to soldiers and veterans, but stops short of a full analysis of how the organizations built and maintained a powerful movement and lobbying effort for access to medical care. Robert D. Leigh, *Federal Health Administration in the United States* (New York, London: Harper & Bros., 1927).

<sup>7</sup> Jeffrey M. Berry; Clyde Wilcox, *The Interest Group Society, Fifth Edition* (New York, Boston, San Francisco: Pearson Education, Inc., 2009). Multiple authors cite the 1860s, and the administration of Ulysses S. Grant as the origin point of lobbying in the U.S., but Elizabeth Clemens points to the Progressive era as a turning point for grassroots, interest group lobbying efforts. It was then, according to Clemens, when interest groups were sustained not only by financial resources (as their nineteenth century counterparts were) but by “extrapartisan voting blocs.” Elizabeth S. Clemens, *The People's Lobby: Organizational Innovation and the Rise of Interest Group Politics in the United States, 1890-1925* (Chicago, Illinois: University of Chicago Press, 1977). At least one author points to eighteenth century U.S. veterans’ groups as the world’s first lobbyists. Lionel Zetter, *Lobbying: The Art of Political Persuasion* (Petersfield, Hampshire: Harriman House, 2011), 6-7. Other useful works on lobbying include: Alan Rosenthal, *The Third House: Lobbyists and Lobbying in the States* (Washington, D.C.: CQ Press, 2000); Margaret Susan Thompson, *The Spider Web: Congress and Lobbying in the Age of Grant* (Ithaca, NY: Cornell University Press, 1986); Ronald J. Hrebenar, *Interest Group Politics in America* (Armonk, New York: Sharpe M.E., Inc., 1997).

aggregate interests of the community.”<sup>8</sup> Madison, like many after him, saw the groups as a sort of necessary evil, a product of the larger idea that people living in a free society will pursue their self-interest.

Political scientists have largely moved away from the “pluralist” theory of interest group politics, which dates from the mid-twentieth century and posited that interest groups were, by and large, good for society. While interest groups did historically increase the “democratic capacities” of their members, they did not represent the broad swath of citizenry, and their presence did not in itself ensure an egalitarian democracy.<sup>9</sup> Indeed, until the middle to late twentieth century, minority Americans who organized among themselves hardly had the kind of access to Congress that their white counterparts did.<sup>10</sup>

Interest groups focus on a variety of issues – from agriculture and the environment to education and reproductive rights – but scholars single out veterans’ groups as being particularly powerful. They qualify as one fundamental part of particular subgovernments, subsystems, or issue networks, wherein advocates “help bureaucrats build coalitional support for programs in Congress and provide information and electoral support for legislators. Legislators, in turn, create programs for the bureaucrats, and bureaucrats administer benefits to the groups.” Since

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<sup>8</sup> James Madison, “The Federalist No. 10,” *Daily Advertiser* November 22, 1787.

<sup>9</sup> Wilcox, *The Interest Group Society, Fifth Edition*, 2. Multiple authors cite the 1860s, and the administration of Ulysses S. Grant as the origin point of lobbying in the U.S., but Elizabeth Clemens points to the Progressive era as a turning point for grassroots, interest group lobbying efforts. It was then, according to Clemens, when interest groups were sustained not only by financial resources (as their nineteenth century counterparts were) but by “extrapartisan voting blocs.” Clemens, *The People's Lobby: Organizational Innovation and the Rise of Interest Group Politics in the United States, 1890-1925*. At least one author points to eighteenth century U.S. veterans’ groups as the world’s first lobbyists. Zetter, *Lobbying: The Art of Political Persuasion*, 6-7. Other useful works on lobbying include: Rosenthal, *The Third House: Lobbyists and Lobbying in the States*; Thompson, *The Spider Web: Congress and Lobbying in the Age of Grant*; Hrebennar, *Interest Group Politics in America*.

<sup>10</sup> Dara Z. Strolovitch, *Affirmative Advocacy: Race, Class, and Gender in Interest Group Politics* (Chicago, Illinois: University of Chicago Press, 2008). Attempts by women and veterans of color to gain access to the American Legion and DAV will be discussed later in this chapter.

interest groups provide support for bureaucrats and legislators, “all of the actors within a subsystem share the same basic policy goals,” James Wright notes. “Policy making within subsystems entails little conflict, and the policies that result are generally distributive, or pork barrel in nature, having concentrated benefits and dispersed costs.”<sup>11</sup>

Interest groups in subsystems – whether they focus on veterans, senior citizens, farmers, or other constituents – have extensive *access* to Congress, which, according to Christina DeGregorio and other scholars, is the most fundamental precondition necessary for exerting political influence. In such an arrangement, DeGregorio argues, “advocates and (legislative) leaders each have something to gain from the relationships they enter.”<sup>12</sup>

Veterans’ groups also generally possess another crucial political strength: they face little or no opposition from “other political actors.”<sup>13</sup> As one scholar puts it, “if benefits are too generous, who is going to fund the lobby to fight against disabled veterans?”<sup>14</sup> By virtue of these facts, by the early 1940s, V.O. Key called the American Legion “one of the most influential pressure groups.”<sup>15</sup>

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<sup>11</sup> John R. Wright, *Interest Groups and Congress: Lobbying, Contributions, and Influence* (Boston, Massachusetts: Allyn & Bacon, 1996), 168-71. Over time, the idea of subgovernments and iron triangles has been deemed “simplistic and wrong,” according to Carol S. Weissert and William G. Weissert. But, they say, the concept still aptly applies to veterans’ groups. Carol S. Weissert; William G. Weissert, *Governing Health: The Politics of Health Policy, Third Edition* (Baltimore, Maryland: Johns Hopkins University Press, 2006), 147-49.

<sup>12</sup> Christine A. DeGregorio, *Networks of Champions: Leadership, Access, and Advocacy in the U.S. House of Representatives* (Ann Arbor, Michigan: The University of Michigan Press, 1997), 87-89.

<sup>13</sup> Lack of political opposition is one condition that allows certain interest groups to exert influence, according to Anthony Nownes. Other conditions mentioned by Nownes will be further discussed in Chapter Six. Anthony J. Nownes, *Pressure and Power: Organized Interests in American Politics*, ed. Allan J. Cigler, The New Directions in Political Behavior Series (Boston, Massachusetts; New York, New York: Houghton Mifflin Company, 2001).

<sup>14</sup> Jeffrey M. Berry, *The New Liberalism: The Rising Power of Citizen Groups* (Washington, D.C.: Brookings Institution Press, 2000), 46.

<sup>15</sup> V.O. Key Jr., “The Veterans and the House of Representatives: A Study of a Pressure Group and Electoral Mortality,” *The Journal of Politics* Vol. 5, no. No. 1 (1943).

In order to understand where interests and preferences come from, and how a group gains access and power, says David R. Mayhew, one must examine the events surrounding its existence and growth. Wars, he argues, are extreme examples of such events. They “can generate new problems and open up policy windows, thus often fostering new policies, but they can also generate new ideas, issues, programs, preferences, and ideologies...”<sup>16</sup> They can lead to the creation of new organizations, which “tend toward stickiness... and are particularly good at rendering the effects of wars long-lasting.”<sup>17</sup> A study of the veterans’ groups of the 1920s reveals the birth of a crucial issue network and shows that interest group politics and the events that bring them about can indeed lead to lasting, “sticky” political change.

Theda Skocpol questions the idea that veterans’ groups have historically been as all-powerful as some posit. In her discussion of the liberalization of Civil War pensions in the 1880s, she argues that a “pressure group thesis” overstates the influence of the major veterans’ advocacy organization, the Grand Army of the Republic. The group, she says, did little lobbying for the lenient 1880 Arrears Act, which “seems to have affected the [Grand Army of the Republic] more than vice versa.” The Civil War era group, Skocpol notes, saw its largest membership gains only after the increased benefits were secured, not in the lead-up to the fight.<sup>18</sup>

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<sup>16</sup> David R. Mayhew, “Wars and American Politics,” *Perspectives on Politics* Vol. 3, no. No. 3 (September 2005): 473-5.

<sup>17</sup> *Ibid.*: 485.

<sup>18</sup> In the late nineteenth century, Skocpol says, the liberalization of pensions was a product of “organizational interests” of politicians themselves, and a larger competition for voters among the Republican and Democratic parties. Skocpol, *Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States*, 111-15. Likewise, Theodore Marmor argues that advocacy groups of the aged “were the result more than the cause” of the tense political climate surrounding the 1965 passage of Medicare, the health insurance program that covers elderly Americans. But Marmor notes that the growing power of senior citizen advocacy groups provided a visible counterpart to the American Medical Association, which vehemently opposed a federal insurance program. Thanks to the increasingly visible presence of organizations of the aged, the A.M.A. – and its statements of vehement opposition to a federal insurance program – risked “being labeled the enemy of America’s senior citizens.” Such a prospect led the powerful doctors’ group to embrace a “willingness to offer alternatives,” rather than “nothing but

As the American Legion waged successful battles in the early to mid-1920s for the establishment of the Veterans' Bureau and increased access to veterans' hospitals, the organization actually saw membership numbers fall from a high of approximately 795,800 in 1920 to 609,000 in 1926. Only after increased rights were secured, and especially with the onset of the depression of the 1930s did the organization's membership rolls increase.<sup>19</sup> But rising numbers of adherents are not the only measure of political action or effectiveness. In the early 1920s, the American Legion and DAV served as crucial partners for bureaucrats who argued for more and better hospitals for former soldiers. Their advocacy efforts helped justify calls for increased government spending by putting a human face on the problem and bringing it to public attention; they played an integral role in the establishment of a nationwide veterans' hospital system.

Skocpol's argument brings up yet another important question: what motivates people to join advocacy organizations like the American Legion and DAV?<sup>20</sup> David Gerber argues that an over-emphasis on political motives and advocacy "misconstrues" the goals of individual veterans. By joining forces with their fellow ex-service members, Gerber argues, veterans strived to fulfill "ideological, social, recreational, commemorative, and solidaristic" needs, not a hunger for government benefits. Often, he notes, compensation payments or medical care from the government were represented by veterans' organizations either as a threat to constituents' independence, or as necessary only in order to help an ex-service member achieve a modicum of

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the status quo," as it had prior to the rise of citizens' pressure groups. Theodore R. Marmor, *The Politics of Medicare* (Chicago, Illinois: Aldine Publishing Company, 1973), 24, 28.

<sup>19</sup> The membership high point of the period – of approximately 1 million – was reached in 1931. The Membership and Post Activities Section, "The American Legion National Membership Record, 1920-2006" 2006. American Legion Library, Indianapolis, Indiana.

<sup>20</sup> For an overview of the debate surrounding these questions, see William P. Browne, *Groups, Interests, and U.S. Public Policy* (Washington, D.C.: Georgetown University Press, 1998), 11-15.



self-sufficiency.<sup>21</sup> The activism of the American Legion and the DAV after World War I bears out Gerber's idea that veterans joined forces with one another for a variety of social reasons, and that some veterans, in fact, strongly opposed the idea of gaining access to welfare benefits based solely on their status as ex-service members. But it also reinforces the notion that a battle for government entitlements was an important pillar of veterans' organizations' general agendas.

I interrogate the AL and DAV mainly as political organizations, while arguing that their cultural values and identities were central to their legislative successes. My approach of looking at interest groups' interaction with the state is not intended to reduce the entire experience of individual veterans to a fight for institutional or monetary benefits. It is an attempt to assess how political capital was garnered and spent. The DAV and AL served a variety of purposes; many joined the groups with no knowledge of – or, indeed, in spite of – their efforts on Capitol Hill. But as the Legion and DAV became strong advocates for ex-service members with whom the general public could readily sympathize – especially those who had incurred maladies while in the line of duty – they gained potential members, added legitimacy, and a unifying mission.

*“Future lies in your aid now”: Medical care as a righteous, unifying cause*

The American Legion and other groups took on medical care as a political rallying point for a variety of reasons. There were indeed major fundamental problems with health services being administered by the Bureau of War Risk Insurance (BWRI), army, and Public Health Service (PHS), and fighting for better conditions fell within the purview of the groups' missions. Furthermore, the quest for medical care provided a primary and unifying rallying point for veterans' groups that encountered divides on other issues. Legion state representatives argued,

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<sup>21</sup> Gerber, "Disabled Veterans, the State, and the Experience of Disability in Western Societies, 1914-1950."

for example, over the importance of issues such as “the Asian menace”; western representatives thought that threat should constitute a primary focus of the organization while southern and eastern representatives were more concerned with the effects of immigrant and African American populations in cities. Leaders also disagreed about the desirability of providing “adjusted compensation,” or bonus payments, for veterans – some thought it was an inappropriate demand for charity while others called it justice. The provision of hospital care for ill and injured ex-service members, on the other hand, was something upon which virtually everyone could agree: injured and ill ex-soldiers should, of course, be housed in satisfactory institutions in relatively close proximity to their homes.<sup>22</sup> Press coverage of ill-treated, ailing veterans mobilized both prospective members and the general public around the idea that veterans’ groups were doing good and noble work for those most in need.<sup>23</sup>

During the Legion’s earliest meetings, some leaders and members argued that medical care for disabled soldiers and veterans was failing, and that the organization should provide strong advocacy on the issue. In May 1919, at the group’s first stateside caucus at St. Louis, Missouri’s Shubert Theater, Harry Mock, an Illinois surgeon who had served in the Army Medical Corps, took the floor. He noted that there would be approximately 300,000 soldiers, sailors, and marines released from the military with a disease or disability, who would not only be “discouraged” because of their handicaps, but also would resist joining the Legion unless “stimulated to do so.” In order to tackle the latter challenge, Mock suggested creating a division

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<sup>22</sup> This corresponds with Stephen Ward’s argument that “unity” among veterans was most easily achieved in respect to issues such as the “treatment of disabled men.” Ward also argues that pensions, bonus payments, and “the belief that the state and the public owed them more gratitude than they received” were also unifying issues. In the case of the Legion and the DAV, however, the latter occasionally proved somewhat divisive. *The War Generation: Veterans of the First World War*, 7-8.

<sup>23</sup> According to William Pencak, “the Legion won victories by demonstrating that it worked unselfishly for the disabled.” Pencak, *For God and Country: The American Legion 1919-1941*, 175.

of disabled soldiers of the American Legion. But according to Mock's fellow representatives, organizational unity, based on the virtue of having served, was paramount. His proposal was rejected. But the fact that the matter was even discussed indicates that within the very first months of the Legion's formation, its leadership recognized that disabled and ill soldiers would prove an important constituency.<sup>24</sup>

Further to this point, at the group's first national convention in November 1919, members passed a lengthy resolution regarding governmental obligations to soldiers and veterans, which included the stipulation that legislation be passed "making sufficient appropriation to provide adequate hospital and sanitarium facilities for the care and treatment of all persons discharged from the military and naval service..." Additionally, it said, the government should pay for "surgical treatment... irrespective of the service origin or aggravation of their disability..." Iterations of the resolution were passed each year through the early 1920s.<sup>25</sup> Such measures became the blueprint for the Legion's pro-active Legislative Committee, which lobbied on Capitol Hill in the hopes of making the interests of the organization a reality.

Within one year of the Armistice, the American Legion was using its growing national network to gather first-hand evidence of the shortfalls of various government agencies in the provision of medical care to soldiers and veterans. In November 1919, the AL's National Executive Committee received a visit from an official of Battle Mount Sanitarium, one of the Soldiers' Homes where discharged soldiers with tuberculosis were treated courtesy of the Bureau

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<sup>24</sup> The Society of American Legion Founders, "Proceedings and Committees Caucus of the American Legion, St. Louis Missouri, May 8, 9, 10, 1919" 1919, 146. Reports of National Officers, American Legion Library, Indianapolis, Indiana. For a general discussion of the St. Louis Caucus as "a raucous affair," see Thomas A. Rumer, *The American Legion: An Official History 1919-1989* (New York: M. Evans & Company, Inc., 1990), 39-56. Also see, Pencak, *For God and Country: The American Legion 1919-1941*, 58-62.

<sup>25</sup> "Committee Reports and Resolutions Adopted at the First National Convention of the American Legion, Nov. 10, 11, 12, 1919, Minneapolis, Minnesota (Unofficial Summary)", 1919, 29. American Legion Library, Indianapolis, Indiana.

of War Risk Insurance. Post Adjutant Ranson, who, before working at the sanitarium, had been a patient there, described a dire situation. Men who requested treatment were being ordered to the institution, which not only lacked adequate space and food, but was also intended primarily to treat “stomach and rheumatism troubles.” The sanitarium doctor, Ranson said, was a “wonderful surgeon, but not a T.B. man.” It was not that Ranson and his fellow ex-servicemen were looking for a handout; he, for one, had sought care from a public facility because he did not “want to stay around home and run the risk of giving the disease to some of my relatives.” But, conditions were so bad at the institution that cure seemed impossible. For example, Ranson noted, wages at Battle Mount were so low that only former patients were willing to work there, many of who were still “spitting bugs – as we call it – or spitting T.B. germs.” One patient thought conditions were so dire that he wrote to the Public Health Service asking to be transferred to a private sanitarium. The PHS sent him to a facility in St. Paul Minnesota that was full to capacity, and he was unable to obtain treatment.<sup>26</sup>

Some members of the National Executive Committee were more sympathetic to Ranson’s cause than others. A representative from South Carolina voiced his concern that more facilities and services may not necessarily be better for soldiers and veterans. He had served as a medical examiner for the Bureau of War Risk Insurance, he said, and as such, was authorized to provide any treatment necessary to patients who visited him. “It is their own fault,” he said of ex-soldiers who failed to get proper treatment for their ailments. But another representative disagreed; he argued that the Legislative Committee should take on the issue by passing a resolution to lobby

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<sup>26</sup> "Minutes of the National Executive Committee of the American Legion, Held in Minneapolis, Minnesota, November 13, 1919", 1919, 78-85. National Executive Committee Minutes, The American Legion Library, Indianapolis, Indiana. For a comprehensive and detailed picture of army TB care during the first part of the twentieth century, see Carol R. Byerly, *Good Tuberculosis Men: The Army Medical Department's Struggle with Tuberculosis* (Washington, D.C.: Borden Institute, Forthcoming).

for legislation to provide for more extensive hospital facilities.<sup>27</sup> The latter, more sympathetic perspective prevailed in the American Legion in 1919 and the early 1920s.

By working with government bureaucrats, Legion representatives were able to compile a body of evidence that indicated that the medical care problem was systemic, and not the product of irresponsible or irrational demands from ex-service members. One Legion report pointed out that eight different entities – the Bureau of War Risk Insurance, the PHS, the Federal Board for Vocational Education, the National Home for Disabled Volunteer Soldiers, the Medical Department of the Army, the Medical Department of the Navy, and private and public hospitals – were involved in providing care for veterans. Practically speaking, this meant that on July 30, 1920, there were 17,981 war risk patients being treated in more than one thousand hospitals throughout the U.S. The report quoted R.G. Cholmeley-Jones, the Director of the BWRI, noting that the ‘situation’ was ‘manifestly unsatisfactory to the disabled ex-service men and to the Government...’ Soldiers still being treated in military hospitals, the report said, were “quite unhappy and dissatisfied.” They were “tired of hospital life,” which featured sub-par food and a corps of social service agencies, nurses, and doctors whose ranks had been greatly depleted since the Armistice. They often insisted on being discharged “before being cured in the hope of receiving better treatment” as ex-service men. But the report contended that as veterans, they would continue to encounter limited and flawed services.<sup>28</sup>

Tuberculosis and neuropsychiatric patients proved the greatest challenges to the system, according to experts quoted in the Legion report. As Battle Mount Sanitarium employee Ranson

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<sup>27</sup> "Minutes of the National Executive Committee of the American Legion, Held in Minneapolis, Minnesota, November 13, 1919", 78-85.

<sup>28</sup> "Report of the Committee of the American Legion on Hospitalization and Care of Sick and Disabled Ex-Service Men and Women ", 1920. Rehabilitation reports 1920-1930, The American Legion Library, Indianapolis, Indiana.

had noted in the Executive Committee meeting the year prior, there were not enough facilities to treat people with TB. Ex-service members were being sent to “county farms, poor houses and State Institutions” for treatment, where they were surrounded by charity cases. There, in spite of having their care funded by the government, veterans were “unhappy and displeased.” Furthermore, “their relatives resent the fact that, despite the sacrifice made by these men, they are not provided with the very best care which the Government can afford.”

The “gravest problem throughout the country,” the report said, was ‘the proper hospitalization and care of nervous and mental cases...’ The issue at hand was multi-faceted: there were not enough facilities to provide care for all those who sought it. Also, many reported neuropsychiatric problems after being discharged from service, leaving open the question of government liability for treatment. ““Through failure to provide treatment,”” argued Thomas W. Salmon, Chief Executive Officer of the National Committee for Mental Hygiene and Chief Consultant in Psychiatry for the American Expeditionary Force, ““many soldiers with curable mental diseases will become permanently insane.”” Such men were being ““neglected”” and ““abandoned,”” according to Salmon. Providing for their proper care required a ““modern conception of needs... instead of incredibly complacent indifference,”” he argued. Salmon cited the potential of the American Legion to serve as liaison between veteran and government. ““Believe Legion has great opportunity in securing treatment needed by Comrades in greatest distress,”” he said in a telegram to the hospitalization committee. ““Future lies in your aid now.””<sup>29</sup> Doctors and government officials eager to see health facilities improve turned to citizens’ groups to advocate for their cause.

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<sup>29</sup> "Report of the Committee of the American Legion on Hospitalization and Care of Sick and Disabled Ex-Service Men and Women", 1920. For more on Thomas Salmon, see Frankwood E. Williams, "In Memoriam, Dr. Thomas W. Salmon," *Bulletin of the New York Academy of Medicine* Vol. 3, Issue 11(November 3, 1927). Also see Chapter Six of this dissertation.

Behind the closed doors of Executive Committee meetings, Legion leaders spoke matter-of-factly about the group's potential influence. "It seems to me that our work will largely center around Washington," said Legion co-founder Theodore Roosevelt, Jr. in May 1919. "There are a great many things, such as insurance, employment, and all that sort of work, which at this particular moment we have to take up."<sup>30</sup> By early 1920, Legion representatives were decidedly self-assured about their power on Capitol Hill. In a discussion of legislation pertaining to soldiers receiving cash bonuses, one representative pointed out to his fellow Legionnaires that "Congress is waiting to hear from the American Legion... its (*sic*) up to us to tell them what we WANT; they will give it to us (*emphasis in the original*)."<sup>31</sup>

To many Legion leaders, taking on the cause of fighting for rights for the disabled and ill was not only worthy in itself, but also seemed like a powerful means of helping the organization gain public support and political legitimacy. The Legion needed to "emphasize two things," Chaplain John Inzer told the Executive Committee in June 1919. "Pure democracy and unpolluted Americanism, and that we are going to take care of the discharged and disabled soldiers. With that kind of a program the whole country is back of us." The leftist Soldiers and Sailors League, on the other hand, had asked for a "\$500.00 bonus for each man," Inzer said, adding incredulously, "They are going to kill the organization right there."<sup>32</sup> Inzer implied that by partaking in strategic messaging about selective ideals of "Americanism," and debts to

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<sup>30</sup> "National Executive Committee Minutes of Meeting, May 10, 1919", 2. National Executive Committee Minutes, The American Legion Library, Indianapolis, Indiana.

<sup>31</sup> "Minutes of Meeting of the National Executive Committee of the American Legion, Indianapolis, Indiana, February 10, 1920", 37. National Executive Committee Minutes, The American Legion Library, Indianapolis, Indiana.

<sup>32</sup> "Committee Meeting, June 9, 1919". American Legion Complete Minutes of National Conventions The American Legion Library, Indianapolis, Indiana.

citizen-soldiers who not only fulfilled them, but incurred sicknesses or disabilities in the process, the Legion would prevail among its competitors.

Legion members and official reports repeatedly noted that those who were disabled in service had sacrificed the most, and should be the top priority of the organization. "The Congress of the United States and the responsible people have been so derelict in their duty to these men that it is fitting at this time to call public attention to it and take some affirmative action," said Legion representative Foreman of Illinois, at the March 1920 executive committee meeting.<sup>33</sup> He went on to describe a dire situation in his home state, where there were not enough beds in government institutions and mentally ill ex-soldiers were being sent to charity facilities against the will of their families.

Foreman's appeal for the Legion to support an emergency appropriation for the building of facilities was met with applause. Representative Emery of Michigan seconded Foreman's sentiment, adding that tubercular ex-soldiers were "walking the streets and they ought to be hospitalized." In Michigan, he said, the problem was not a lack of funds, but a lack of organizational power on behalf of the Public Health Service, which was charged with caring for the ex-soldiers. The PHS had funding, but it was "a hard thing" to find the buildings, doctors, and nurses that would constitute a proper hospital.

Representative Hoffman, of Oklahoma, concurred, saying there were three thousand tubercular ex-soldiers in his state with nowhere to turn. "They simply send them down to New Mexico or Texas but the conditions have been investigated there and are not

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<sup>33</sup> "Minutes of Meeting of the National Executive Committee of the American Legion, Held in Washington, D.C., March 22-24, 1920", 52. National Executive Committee Minutes, The American Legion Library, Indianapolis, Indiana.



satisfactory and these men... want to stay in their own home and among their own friends,” Hoffman said.<sup>34</sup>

Hoffman also expressed frustration with the idea that the American Legion should assist the PHS in locating viable facilities, which he saw as “passing the buck.” “We weren’t asked for any conditions when we were called into the Service,” Hoffman said, “nor told that if we became injured you had to hunt out a place and lie down in it.” The American Legion was becoming the “catch basin” for doing the complicated work of a variety of government agencies, he argued.<sup>35</sup>

According to Delaware Legion Representative Thomas Miller, chairman of the organization’s Beneficial Legislation Committee, the Legion should be viewed more as a proactive lobbyist than a thankless workhorse. In response to members’ concerns about government services for the disabled, he noted the sundry bills that the Legion was currently pushing to have passed. They included the Wasson Bill, which was intended, among other things, to establish 14 district offices throughout the country, in addition to unlimited sub-offices for handling the claims of War Risk Insurance patients. Legion Legislative Committee members were also advocating for passage of the Darrow Bill, providing \$100 per month for all ex-soldiers enrolled in government-sponsored vocational training, and the Rogers Bill, which would consolidate veterans’ services overseen by the PHS, the Bureau of War Risk Insurance, and the Vocational Training Boards Rehabilitation under one Cabinet officer. (The latter Bill, we will see, served as an early forerunner to the August 1921 creation of the Veterans’ Bureau.) Finally, in

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<sup>34</sup> Ibid., 52-62.

<sup>35</sup> Ibid., 61-2.

addition to helping ensure that ex-soldiers were not discharged prematurely from military hospitals, Miller reminded the Executive Committee, the Legion was also actively attempting, through its local chapters, to assist the government in finding the more than 30,000 beds needed by War Risk Insurance patients. Miller's main concern, he said, was to demonstrate that "your Committee and your National Organization have not been recreant to your resolutions passed at (the first stateside AL meeting in 1919 in) Minneapolis saying that the duty of The American Legion first was to the disabled men and the families of the fallen."<sup>36</sup>

*"To save those men from the doctrines of the radical agitator": The cash bonus and benefits for all versus some*

Legion leaders advocated for injured and ill veterans because there was evidence that the medical system they encountered was gravely flawed. But their drive and persistence were at least partially fueled by a desire to stave off radicalism among seemingly vulnerable veterans by bolstering a perception of the U.S. state as grateful and generous. In order to maintain a pure sense of love of country, the Legion claimed, veterans needed certain things from their government, including good medical care. The groups argued for the justness of veterans' access to unique rights and welfare based on the fact that they had taken up arms for the country, but also on the notion that they were "100 percent American." The conservative, anti-egalitarian leanings of the Legion allowed the groups to win the ears of members of Congress when other groups could not. The same radical groups and individuals that were shut out from Capitol Hill, however, influenced the agenda of what became mainstream veterans' advocacy organizations and by extension, helped lay the foundation of the nation's largest federally-sponsored hospital

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<sup>36</sup> Ibid., 55-60.

system. The Legion's campaign against leftist ideologies and groups was part and parcel of its effort to obtain special privileges for veterans. The organization employed anti-radical rhetoric and declared its members super-patriots. Honoring requests for free medical care, the Legion said, was the least the government could do for such citizens. The organization's argument that veterans deserved specific rights was contingent on the acceptance of the notion that others were less worthy of the same. Its leaders defined white, male ex-service members as defenders of liberty against leftists and "slackers," who had failed to enlist or otherwise avoided service. In so doing, the Legion capitalized on a tense contemporary political climate and helped instantiate the idea of a venerated and privileged citizen-veteran class.

In the immediate post-war years, Americans confronted new social realities and a growing sense of discontent with their elected officials. As increasing numbers of foreign-born and black workers made their way to American cities, anti-immigrant and anti-leftist sentiment soared, and tensions between whites and minorities escalated. Labor unrest, which had been building throughout the 1910s, erupted anew in 1919 as the economy slowed and unions and workers organized strikes across the country. Meanwhile, American women were well on their way to winning the right to vote. To many political and social conservatives, it seemed that a new and disturbing order was emerging.<sup>37</sup> As the war came to a close, there was also a growing sense that the Democrats in power had bungled crucial aspects of war planning. In the congressional elections of 1918, Americans ushered Republicans into the majority in both the

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<sup>37</sup> Two of the most useful general references on the U.S. during the Great War are: David M. Kennedy, *Over Here: The First World War and American Society* (New York: Oxford University Press, 1980), Robert H. Zieger, *America's Great War: World War I and the American Experience* (Maryland: Lanham, 2000). On the intellectual history of this period, and the many social and cultural tensions by which it can be characterized, see Daniel H. Borus, *Twentieth-Century Multiplicity: American Thought and Culture, 1900-1920*, American Thought and Culture (Lanham, Maryland: Rowman & Littlefield, 2009).

House and Senate, thereby declaring their frustration with President Woodrow Wilson and the Progressive wing of the Democratic Party with which he was popularly associated.<sup>38</sup>

At an especially tense moment, the Legion presented itself as a defender of freedom, appealing to “middle-class Americans’ classless vision of Americanism.”<sup>39</sup> On the cover of the organization’s weekly magazine in July 1919, the Legion was represented as a strapping white man, tossing off his army coat in front of a pillar labeled, “American Institutions.” He eagerly pursued a hunch-backed, dark-haired, wild-eyed man toting a bomb, presumably to wrestle the implement from him. The message was clear: the Legion was a crucial protector of the country’s sacred freedoms against the most threatening menaces of the time.<sup>40</sup> A similar cover a month later depicted the same towering personification of the American Legion, this time with his hand on the shoulder of the Statue of Liberty, glancing down at figures marked “Bolshevist,” “IWW,” “Propagandist,” and “Alien Slacker.” On this cover, the Legion was referred to as the “big brother” of liberty.<sup>41</sup> Indeed, year after year, Legion annual conventions tackled the problems of radicalism and what was perceived as overly rampant immigration. Special scorn was reserved for foreign-born individuals who failed to enlist during the war – so-called “alien slackers.”

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<sup>38</sup> For overviews of war-era national politics, see Seward W. Livermore, *Politics Is Adjourned: Woodrow Wilson and the War Congress, 1916-1918* (Middletown, Connecticut: Wesleyan University Press, 1966); Joseph A. McCartin, “The First World War,” in *The American Congress: The Building of Democracy*, ed. Julian E. Zelizer (Boston; New York: Houghton Mifflin Company, 2004). According to McCartin, from 1916 through 1918, President Wilson struggled to gain support for his policies from a contentious Congress in which unity was difficult to find. Wilson found himself facing strong opposition from anti-war Democrats and their fiscally conservative, anti-interventionist Republican colleagues. At the same time, he was able to gain support from interventionist Republicans, such as Henry Cabot Lodge, who were long-time proponents of increased military funding.

<sup>39</sup> Pencak, *For God and Country: The American Legion 1919-1941*, 171-75.

<sup>40</sup> “Cover Art,” *The American Legion Weekly* July 11, 1919.

<sup>41</sup> “Her Big Brother,” *The American Legion Weekly* August 5, 1919.

Even among those who had served, there were some who were more worthy than others, according to the Legion. As Regin Schmidt has shown, AL officials assisted with – even helped to spur – the Federal Bureau of Investigation’s monitoring of left-leaning veterans’ advocacy groups. Using tips from Legion representatives, FBI Director J. Edgar Hoover surmised that the World War Veterans of America was a front organization for a threatening radical cabal of labor unions and the International Workers of the World (I.W.W.), aiming to take advantage of unsuspecting veterans and orchestrate a takeover of the country’s government.<sup>42</sup>

In fact, the WWVA was among the first proposed advocacy organizations to represent ex-service members who had served in the World War; in February 1919, Representative George K. Denton (D-IN) sought federal recognition for incorporation of the group. Denton argued that the WWVA should be based in Indiana, since the first American killed after the U.S. declared war was from that state.<sup>43</sup> By 1923, one newspaper referred to the organization as “highly radical... and in reality a subsidiary of the Communist party of America.”<sup>44</sup> “To counteract the loyal and patriotic actions of the American Legion,” the *Los Angeles Times* reported, “the Communists have secured control (if they did not inspire its formation in the first place) of the World War Veterans.”<sup>45</sup>

A similar fate awaited the Private Soldiers’ and Sailors’ Legion, which sought to organize only non-commissioned officers to demand that military higher-ups be held accountable for their

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<sup>42</sup> Regin Schmidt, *Red Scare: F.B.I. And the Origins of Anticommunism in the United States* (Copenhagen, Denmark: Museum Tusculanum Press, 2000), 109-15.

<sup>43</sup> Incorporation of the World War Veterans of America, Subcommittee No. 1 on Judiciary, House, H.R. 14818, Sixty-Fifth Congress, Third Session, (Washington, D.C.: Government Printing Office, February 7, 1919).

<sup>44</sup> “An Unfair Scheme,” *The Atlanta Constitution* November 6, 1923.

<sup>45</sup> “Reds Plot to Destroy All Police Protection,” *Los Angeles Times* July 23, 1923.

errors during the war, and that all veterans be granted jobs or land.<sup>46</sup> By its own account, in the immediate post-war years, the Private Soldiers' and Sailors' League attracted as many as 700,000 members.<sup>47</sup> The group was vocal in debates regarding soldiers' bonuses and other pertinent issues; its President, Marvin Gates Sperry, was called to testify before Congress on such matters. In early 1922, however, Sperry was accused of embezzlement. Though the charges were later dismissed as being wholly unfounded, internal conflicts among the Private Soldiers' and Sailors' Legion's leaders rendered the organization all but defunct.<sup>48</sup> More generally, the negative publicity surrounding the political leanings of the WWVA and the Private Soldiers' and Sailors' Legion undercut membership, and helped allow the Legion to assume a position as the primary veterans' advocacy group of the time.

The American Legion's occasionally contentious intra-organizational debates about whether or not former soldiers should be granted a cash bonus for their time in service illustrate how central anti-leftist ideology was in the organization's eventual support of government benefits, including medical care. The question of whether veterans should receive post-service payments divided the Legion throughout late 1919 and early 1920; it brought about tough

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<sup>46</sup> Declaration of Principles of the Private Soldiers' and Sailors' Legion of the United States of America, Soldiers' Adjusted Compensation, in Soldiers' Adjusted Compensation Hearings, Committee on Finance, Senate, Part 1, H.R. 14157, Sixty-Sixth Congress, Third Session, (Washington, D.C.: Government Printing Office, December 15, 1920), 51-52.

<sup>47</sup> Pencak, *For God and Country: The American Legion 1919-1941*, 51.

<sup>48</sup> "Ex-Soldier Organizer Is Held as Embezzler; Lobbied for Bonus and Started Buddies' Club," *The New York Times* May 23, 1922; "Buddies' Club Head Faces Court Today: M.G. Sperry Brought from Washington on Embezzlement Charge," *The Sun* May 23 1922. "Sperry Charges Dismissed: Baltimore Magistrate Says He Was 'Fooled' into Issuing Warrant," *The New York Times* May 24, 1922. "Evidence Lacking: Sperry Dismissed... Magistrate Apologizes," *The Sun* May 24, 1922. "Charges Clerks Sold Everything in Office; Only Wallpaper Left," *Washington Post* August 30, 1922.

debates regarding notions of self-reliance, and the proper place of government in individuals' lives.<sup>49</sup>

Plenty of Legionnaires believed that publicly funded cash payments and services for veterans should be as limited as possible, lest they foster dependency. Fighting for compensation for individual ex-service members, they believed, contradicted the organization's commitment to put "something into the Government, not take something out of it..."<sup>50</sup> The Legion was founded to "be a great, American, unselfish organization, that would devote itself to the problems of Americanism and patriotism and not to the obtaining of material benefit for its members," they argued.<sup>51</sup>

Many Legionnaires who did favor cash payments for those who served spoke strenuously against the notion of a bonus, per se, which they deemed "too much like a gift... from the government." Instead, they asked for "adjusted compensation," monetary assistance from the "government to assist the ex-service man in overcoming some of the financial disadvantages incidental to his military or naval service."<sup>52</sup> Furthermore, they pointed out, adjusted compensation was "an obligation of our government to all service men and women," but it was

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<sup>49</sup> A Bonus law did eventually pass – in 1924. It will be discussed in more detail in Chapter Six. The discussions in these Executive Committee meetings had to do with an earlier iteration of Bonus legislation – for a "four-fold" plan. Here, I discuss the relationship between Legion leaders' stances on government benefits in general, and their perceptions of threats of radicalism among former soldiers. For details on the four-fold plan and congressional testimony from Legionnaires surrounding the bill, see Rumer, *The American Legion: An Official History 1919-1989*, 125. For a comprehensive overview of Legion debates about adjusted compensation, and their effect on membership levels, see Pencak, *For God and Country: The American Legion 1919-1941*, 83-4; 170-207.

<sup>50</sup> The quote is from Representative Nelson of Arkansas. "Minutes of Meeting of the National Executive Committee of the American Legion, Held in Washington, D.C., March 22-24, 1920", 248.

<sup>51</sup> The quote is from Representative Hagen of Oklahoma. *Ibid.*, 254.

<sup>52</sup> *Ibid.*, 7.

still “second” in importance to “caring for the disabled and for the widows and orphans of those who sacrificed their lives.”<sup>53</sup>

Legion members who supported adjusted compensation relied on two main arguments: first, they said, adjusted compensation served as the government’s fulfillment of patriotic duty. While in service, doughboys had sacrificed months of salary, and the opportunity to advance in a quickly expanding industrial economy. Congress would merely be paying them an owed debt, they said. Far from selfish, the cash payment was “consistent with the welfare of the whole country.”<sup>54</sup>

Second, adjusted compensation supporters argued, post-service benefits were hardly a selfish means of taking from the government. Instead, they were assets in an ongoing battle for the malleable hearts and minds of ex-servicemen. “We cannot put anything finer into our Government than to do something to save those men from the doctrines of the radical agitator,” said Washington state Legion Representative Wilkeson at a meeting of the National Executive Committee in March 1920. He continued:

We must take some action or urge the Government to take some action which will make it impossible for the agitator to say to him, ‘what has your Government done for you? They have been unsympathetic when you have asked about your War Risk Insurance. They have paid no attention to you. They have been unsympathetic if you have been a wounded man. You have been underrated in many instances as to your disability. The Government has nothing for you whatever.’

Twenty percent of those drafted, Wilkeson noted, were illiterate. “Those are the men that are the prey of the I.W.W.,” he said, and they were to be “pitied not blamed,” if they succumbed to pressure from leftists. “Remember when a man wants sympathy and does

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<sup>53</sup> Ibid., 4.

<sup>54</sup> Legion National Commander Franklin D’Olier quoted in Russell M. Crouse, “To Pay a Debt Is Not to Give a Bonus,” *The American Legion Weekly* March 12, 1920.



not get it, that he is a good, fit subject for the radical agitator.” Spending ten million dollars to “save five hundred ex-service men from becoming good I.W.W.’s,” Wilkeson said, was well worth it.<sup>55</sup> His fears were well-founded: at the time, Washington was a hotbed of labor unrest and tension between conservative veterans and radicals.<sup>56</sup>

The fight for government benefits was central not only to the Legion’s larger mission of saving ex-service members from the menace of radicalism, but also its attempt to gain credibility as a non-elitist group that would take on the causes of the rank and file. In Michigan, said Legion Representative Gansser, “the I.W.W., the labor agitators, got busy early last summer and fall, saying in open meeting and through their labor paper, mind you, that the Legion represented big business, that the Legion never would represent the service man, the rank and file, that the Legion was composed of officers, and tried to put us on the defensive.” At the state AL convention soon after, Gansser noted, the organization “went unanimously on record” in favor of adjusted compensation. In spite of the support, Gansser was disturbed to report that a “hopeless minority” of Michigan Legion representatives had told the press that the organization was against the bonus, and “the mischief was largely done.”<sup>57</sup>

Montana Representative West also characterized the organization’s support of a bonus as being directly related to an attempt to undercut that state’s I.W.W. “agitators.” “We have got our problems out there that you fellows back east here haven’t got,” West

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<sup>55</sup> "Minutes of Meeting of the National Executive Committee of the American Legion, Held in Washington, D.C., March 22-24, 1920", 258.

<sup>56</sup> For more on post-war tensions in the Pacific Northwest, see Tom Copeland, *The Centralia Tragedy of 1919: Elmer Smith and the Wobblies* (Seattle, Washington: University of Washington Press, 1993). Also, Keene, *Doughboys, the Great War, and the Remaking of America*, 168.

<sup>57</sup> "Minutes of the National Executive Committee of the American Legion, Washington D.C., May 18-19, 1920", 30-80. National Executive Committee Minutes, The American Legion Library, Indianapolis, Indiana.

said. The Montana Legion was “pretty near the home and the habitat of the industrial worker of the world,” he said, which spoke openly against the Legion, representing it as “a wolf in sheep’s clothes.” Following his description of hostility between the AL and I.W.W., West noted “the people and soldiers of Montana as a whole are for this proposition.” The Legion’s support of the bonus, West implied, proved that it was no “wolf in sheep’s clothes” but a true friend to all ex-service members.

Washington Representative Jeffrey was even more explicit:

I think that most of the businessmen in our state recognize that the American Legion is the one greatest factor in combating the radical element and will be the greatest factor in stabilizing the laboring element and their employees. We have, in the state of Washington, like my friend from Montana, a hotbed of I.W.W. and reds of the various classes and they are making a great play to the ex-service man in our state to secure them in their ranks and they make this plea that the government has done nothing for the ex-service men and they say to them that ‘you can’t get Congress to do anything to help you now, you join our ranks and we are going to bring about the reform and get those things to which you are entitled.’ Now, there are a few of the illiterate, uneducated men falling for that propaganda. There are a lot more in the balances, who are subject to being taken and converted into the ranks of the radical or of being stabilized by the American Legion. Lots of them haven’t joined the American Legion for the reason that they say they want to see what we can do...<sup>58</sup>

Although many Legion members were ideologically opposed to the idea of a cash bonus, some eventually favored it in order to ensure that the organization did not lose face or membership to other organizations. American Legion representatives believed that pushing for expanded rights for former soldiers was not only ethically sound but was also a means of gaining credibility, and avoiding claims that the group was elitist or detached from common concerns.

In spite of Legion officials’ best efforts to manage public perceptions, the organization’s support of the cash bonus drew the ire of some disabled former soldiers,

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<sup>58</sup> Ibid.

who felt that it indicated that the Legion was prioritizing benefits for *all* veterans too highly, and not doing enough specifically for injured and ill former soldiers. In May 1920, a representative of the Disabled Emergency Officers, Lieutenant Graham, brought his concerns to a Washington, DC meeting of the Legion's National Executive Committee. He said that he deplored the new War Department policy stipulating that all disabled emergency officers would be discharged from military hospitals and released to the care of the PHS on or before July 1, 1920. As things stood, he said, they were being released from the military with no proof of having incurred a disability in service. Upon leaving service, he argued, they should receive cards that noted that their injuries stemmed from their time in the military, and that also contained directions in case the individual fainted or became ill outside of a hospital. Furthermore, Graham told the Executive Committee, "the officers and men in the various different hospitals are very much disgruntled and very much dissatisfied with the attitude of the American Legion." Their "spirit," he said, was "getting lower and lower all the time, perhaps justly." They felt that the Legion should use "at least as much effort for the disabled men as you are using for the bonus." It was clear, Graham said, that the organization had "not been on the job regarding the disabled men."<sup>59</sup>

Graham's testimony was borne out by the coverage of Walter Reed Hospital's newspaper, *The Come-Back*, which reported a rising hostility to both the American Legion and legislation for a bonus payment in the spring of 1920. The Legion started off on solid footing at Walter Reed, but over time, disabled soldiers became increasingly focused on their own concerns and identities, as distinct from those of non-wounded ex-

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<sup>59</sup> Ibid., 129-63.

soldiers. When American Legion National Commander Franklin D'Olier visited Walter Reed Hospital in December 1919, "men crowded into the Red Cross hut... though it was chow time." D'Olier was met with "a burst of applause" when he guaranteed that the Legion would not "appear before the American people as asking for a specific sum of money as payment for service," but would focus on obtaining a "square deal" for all veterans, and prioritize fighting for improved treatment of the wounded.<sup>60</sup> At Walter Reed, a Legion post was established, which held regular, well-attended meetings. Activism increased over time at various hospitals, with patients starting groups of their own focusing on obtaining access to better medical care.<sup>61</sup> But by early 1920, hospital Legion meetings were less popular and the organization was "bending every effort to secure larger attendances at future meetings."<sup>62</sup> In March 1920, the Legion's District Commander felt it necessary to "exhort the Reed men to be punctual in their attendance." For its part, the hospital newspaper re-printed the preamble to the organization's constitution, "owing to a misunderstanding on the part of many men as to what the American Legion stands for."<sup>63</sup>

Apparently, Graham and Walter Reed patients were swayed by arguments of budget-conscious government officials who argued in 1920 and 1921 that disabled soldiers had to choose between supporting a general bonus payment and obtaining their

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<sup>60</sup> "Legion Leader Visits Hospital; Commander D'Olier's Speech Proved Legion Is Back of Wounded Veterans," *The Come-Back* Dec. 17, 1919.

<sup>61</sup> Regarding, for example, the establishment of a post of the Disabled Emergency Officers of the World War, see, "Officer Patients Organize at Reed," *The Come-Back* March 16, 1920. On the establishment of "the disabled men's bureau of service and legislative relief," see "Reed Patients Band Together in Unique Body," *The Come-Back* April 3, 1920.

<sup>62</sup> "Legion Members, Alive or Dead?," *The Come-Back* February 28, 1920.

<sup>63</sup> "Legion Notes," *The Come-Back* March 13, 1920.

own rights and services; there was not enough money, those officials maintained, for the government to provide both. According to former Secretary of War, Henry T. Stimson, “the real bonus issue, now as in the past is whether more than \$2,000,000,000 in gratuities shall be disbursed among the able-bodied veterans or whether several hundred million dollars shall be available annually for the care of the tubercular and mentally disabled, the crippled and handicapped veterans.” Secretary of the Treasury, David F. Houston, made a similar point: “The country must pay a tremendous price for the present and future care of the disabled, and the ability of the country to pay cannot be jeopardized by the distribution of several billions of dollars to their more fortunate comrades.”<sup>64</sup>

Legion officials felt that rising hostility at Walter Reed, and Lieutenant Graham’s complaints, were, to say the least, unjustified. Representative Jones, who had recently addressed Walter Reed Hospital’s Legion post, said members there expressed no hostility toward the organization. Mr. Gibson, of Wisconsin wanted to know “how the blame could be laid on the American Legion.” “Don’t you think,” he said, “it would be a good idea for members of the American Legion like yourself, disabled men, to down any remarks made around the hospitals to lay the blame on the American Legion when the American Legion has done its share and the government has failed to carry out the programme as laid down by the Legion?” Mr. Wicker, of Virginia, pointed out that the Legion had already helped usher to passage important legislation which had tangible benefits for the disabled, and wondered whether disabled soldiers felt that “nothing should be done for the other men who were financially disabled” until all laws concerning those who were wounded or ill were passed. Representative Gansser of

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<sup>64</sup> “Real Bonus Issue Is Based on Whether Disabled or Healthy Veterans Get First Thought, Say Stimson,” *The Come-Back* March 12, 1921.

Michigan was concerned with what he saw as a “continual passing of the buck to the Legion.” “Congress is responsible,” he said, “the people are responsible, the Legion is just as helpless as you are. We are humbly appealing and have the right to petition and that is all.” Representative Barrett of Maryland shared his opinion as well: “I don’t think it right to come into the Executive Committee of the American Legion and say that the American Legion has done this and that and fallen down on the job when it is absolutely wrong.”<sup>65</sup>

If Lieutenant Graham needed proof, Mr. Raege of the Legion’s Legislative Committee offered an exhaustive explanation of the varied efforts of the group on Capitol Hill on behalf of the disabled soldier: the AL had helped obtain one-cent rail fare for disabled men in hospitals who wanted to travel home. It had also acted on some of the very legislation Graham mentioned, including War Department Circular 345, which stipulated that all emergency officers had to be discharged from military hospitals no more than one year after being admitted, and the Stevenson Bill, which would grant retirement benefits to temporary officers. The Legion was limited in the demands it could make, Raege argued, by the reality of the inner workings of congressional committees, as well as existent laws. For example, Graham and other disabled soldiers argued that they should be granted a portion of the War Risk Insurance they had purchased while serving, as compensation for their injury or illness. But, Raege reminded him, the “term insurance that these men bought at the time of the war provided no disability clause...” Even as he used a rhetoric of entitlement to declare that Legion leaders had to lobby their state representatives and senators to pass laws that would grant wounded and ill ex-service

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<sup>65</sup> "Minutes of the National Executive Committee of the American Legion, Washington D.C., May 18-19, 1920", 135-61.

members benefits that no other Americans were privy to, Raege stipulated that there were practical limits to what could be requested.<sup>66</sup>

Raege's remarks offer only a snapshot of the Legion's legislative work. A glance at the organization's robust lobbying efforts provides a window onto the sundry pieces of legislation geared toward disabled veterans under consideration between 1920 and 1922.<sup>67</sup> In 1920, there were no fewer than 473 bills "directly affecting" ex-service members pending in Congress, according to John Thomas Taylor, Chairman of the Legion's Legislative Committee. That was a liberal estimate; the bills had to do with such varied topics as adjusted compensation, Courts-Martial regulations, immigration, and patents and copyrights. But there was one area of focus that received a disproportionate amount of attention: more than one-third of the Legion's 38 self-declared legislative successes in 1920 had to do with laws concerning disabled ex-soldiers. By testifying in Congress and otherwise lobbying, Legion leaders assisted in obtaining \$46 million for the Bureau of War Risk Insurance to fund hospitalization of veterans; securing the transfer of various army hospitals to the auspices of the PHS; and gaining funding to remodel existing army hospitals and Soldiers' Homes for use by the Bureau of War Risk Insurance.<sup>68</sup> Even as they trumpeted the organization's commitment to the disabled, Legion leaders emphasized that the job at hand was far from complete. "A great deal of

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<sup>66</sup> Ibid.

<sup>67</sup> One scholar notes that between 1919 and 1924, the AL "fought for the veteran with the same zeal it fought against the IWW." Pencak, *For God and Country: The American Legion 1919-1941*, 176. I argue that the fight for veterans' benefits was part and parcel of its fight against the IWW and the spread of radicalism.

<sup>68</sup> "Summary of the Proceedings of the Second National Convention, American Legion, Cleveland, Ohio, September 27, 28, 29, 1920", 3-13. Proceedings from Conventions, 1919-1925, The American Legion Library, Indianapolis, Indiana. For more details on this legislation and the care of veterans between 1919 and 1921, see Chapter Four of this dissertation.

satisfaction may be derived from the fact that the general situation of the disabled ex-service man is several hundred percent better than it was a few months ago,” reported *The American Legion Weekly* in September 1920. But “vigilance and effort” was still required. “There is still a stupendous job ahead.”<sup>69</sup>

### *The Legion and minority service members*

The American Legion’s leaders were particularly challenged by the question of what role people of color and white women would play in the organization. After all, members of those groups had served, too, and, ostensibly, the primary purpose of the organization was to provide a forum for all former military personnel. But the organization’s ideal of unity by virtue of holding veteran status had its limits. Although there were some efforts at egalitarianism, the Legion helped instantiate the prevailing prejudices of the time instead of challenging them. In the end, the organization fought most vigorously for rights for white, male veterans, not all veterans.

Cognizant of the growing political and social power of the American Legion, people of color attempted to gain access to the organization. African Americans from various southern states challenged the Legion’s national leaders to rectify contradictions between the organization’s segregationist state constitutions and the stated egalitarian policies of its national constitution. Austin T. Walden, an ex-captain for the 365<sup>th</sup> Infantry, and Charles A. Shaw, a former Lieutenant for the 92<sup>nd</sup> Division, wrote to Legion Headquarters on letterhead from Walden’s Atlanta law office on September 25, 1919. They, along with “several other Colored officers and soldiers who served in the late War,” had applied for membership in the organization, but the Georgia Division had rejected their request. The state constitution, they

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<sup>69</sup> “Progress of the Disabled,” *The American Legion Weekly* September 17, 1920.



were told, only allowed white veterans to join. Walden and Shaw therefore applied on behalf of “thousands of colored soldiers in Atlanta and Georgia,” for permission to establish a separate state organization “composed exclusively of colored men, with representation in the National Convention as provided by the National Constitution of the American Legion.”<sup>70</sup> In fact, similar requests streamed in to the Georgia Legion throughout 1919, according to the organization’s State Secretary, C. Baxter Jones: “We did not anticipate that... there would be as many requests for Charters as there have been,” Jones reported to AL national headquarters.<sup>71</sup> In Louisiana, black soldiers from various regions banded together and referred to themselves as “delegations.” In July 1919, representatives from New Orleans, Alexandria, and Shreveport attempted to gain entry to the state convention in Alexandria, and were told that, “as colored men,” they would not be granted charters from the Louisiana Division. “This information,” they said, came to us “like a thunderbolt from a clear sky.” After being turned away from the state convention, they wrote to national headquarters for “advice.”<sup>72</sup>

As Legion leaders struggled to grow the organization and attract members, they faced dueling perspectives from white members regarding what they commonly referred to as “the negro problem,” or “the negro question.” Some argued that the decision by individual states to reject black ex-soldiers as members “was not in any way a satisfactory solution.” According to Louis H. Bell, a member of the National Executive Committee from Georgia, the acceptance of African Americans by the American Legion there was imperative for the region. “We in the

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<sup>70</sup> "Letter from Austin T. Walden and Chas A. Shaw to the American Legion", September 25, 1919. Georgia – History File – Department – History, The American Legion Library, Indianapolis, Indiana.

<sup>71</sup> "Letter from C. Baxter Jones to Franklin D'olier", September 16, 1919. Georgia – History File – Department – History, The American Legion Library, Indianapolis, Indiana.

<sup>72</sup> "An Open Letter from the Colored Delegation of Louiaiana to the National Executive Committee of the American Legion", July 3, 1919. Georgia – History File – Department – History, The American Legion Library, Indianapolis, Indiana.

black belt of the South are sitting on the edge of a powder keg as far as the race problem is concerned, and are very anxious that all opportunity be given for a smooth adjustment of the situation,” he said. Most white members of the Atlanta Legion chapter, he added, were “embarrassed” by the vote at Georgia’s state convention to reject all black veterans from the organization.<sup>73</sup> John M. Parker, of Louisiana, said he would resign from the Legion if black veterans were forbidden to join. Like Bell, he argued that the organization was in a position to act as a “stabilizer” in the region if it adopted egalitarian policies.<sup>74</sup>

The perspectives of Bell and Parker contrasted sharply with other Southern Legion members, who saw the acceptance of African Americans as a prospective means of guaranteeing turmoil, not promoting progress. State Adjutant of South Carolina, Irvine Belser, ominously predicted that if black veterans were admitted to the organization in that state, “no more white people would care to join, and probably those already members would withdraw.” He argued that no national body – at this point, Legion headquarters were in New York – should dictate to state leaders how to handle “the negro problem.” Southerners, he argued, were “peculiarly qualified” to deal with it themselves.<sup>75</sup> The idea of white and black individuals associating – even if they were all veterans – was simply unthinkable to Belser and many of his Southern counterparts. The Department Commander of Virginia felt the same way. “There will be no colored brethren of either sex” in the Virginia American Legion, he said. The organization was to be “100 percent

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<sup>73</sup> "Letter from Louis H. Bell, Member from Georgia, National Executive Committee, to Col. Henry D. Lindsley, Chairman, National Executive Committee", July 18, 1919. Georgia – History File – Department – History, The American Legion Library, Indianapolis, Indiana.

<sup>74</sup> "Extract of Letter Written by James M. Parker", April 24, 1919. Georgia – History File – Department – History, The American Legion Library, Indianapolis, Indiana.

<sup>75</sup> "Letter from Irvine F. Belser, State Adjutant of South Carolina, to Henry D. Lindsley, Chairman, American Legion", August 30, 1919. Georgia – History File – Department – History, The American Legion Library, Indianapolis, Indiana.

white.”<sup>76</sup> Legion Chairman Henry D. Lindsley answered such correspondence by noting that the general question would have to be discussed at the annual convention. In his reply to Irvine Belser, he delicately noted, “I am, myself, from the South... and I, of course, understand the situation in a general way that pertains to your state relative to this matter.”<sup>77</sup>

In the end, the Legion adopted the state’s rights policy bolstered by Belser and his fellow strident Southerners, though Lindsley and other organization leaders were somewhat embattled about it. At the June 1919 national Executive Committee meeting, in the midst of a debate about the issue, representative Miller of Delaware asked, “Does the tentative constitution as adopted recognize the absolute equality of every member of the A.E.F.?” Indeed, it did, he was told by Chairman Lindsley. “Then can this committee approve a scheme which would tend to inequality?” Miller asked. But the only viable solution was to leave the question to the states, even if some inequality should result, according to Legion Chaplain John Inzer. “The father sometimes has to let (his children) know that he is the boss around there until they get big enough to take care of themselves,” Inzer said. “That represents to my mind the situation of the colored people in the south.” Inzer echoed the sentiments of both fear and paternalism expressed by generations of white southerners by arguing that if African Americans were “given too much rein they will run wild.” Furthermore, he pointed out, in many towns in Alabama, Georgia, and Mississippi, black men and women outnumbered whites; “so if you threw the whole thing wide open, it would cause unlimited trouble.”<sup>78</sup>

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<sup>76</sup> "Letter from W.L. Price, Department Commander, Virginia, to Lemuel Bolles", September 18, 1920. Administration & Organization Files -- Membership -- Black -- Folder 1, The American Legion Library, Indianapolis, Indiana.

<sup>77</sup> "Letter from Henry D. Lindsley to Irvine F. Belser", September 15, 1919. Georgia – History File – Department – History, The American Legion Library, Indianapolis, Indiana.

<sup>78</sup> "National Executive Committee, Minutes of Meeting, June 9, 1919", 130-40. National Executive Committee Minutes, The American Legion Library, Indianapolis, Indiana. According to Eugene Genovese, slaveholders often

Throughout the country, segregated posts were established. As William Pencak has pointed out, the bulk of Legion leaders chose not to risk losing the support of Southern whites and instead, allowed each state to reach its own conclusion about extending membership privileges.<sup>79</sup> The largest black post was in Louisville Kentucky, with 110 members. The Legion's failure to restrain the exclusionary, segregationist impulses of its Southern constituents had serious implications for growing the organization's membership: in some regions of the South, more than half of A.E.F. troops were black.<sup>80</sup>

By virtue of their relatively smaller numbers in comparison with white veterans, some minority groups posed less of a threat in the eyes of the Legion than did African Americans. American Indians, for example, could be admitted and even celebrated within the organization; in 1919, the Legion adopted as official policy the tenet that "all American Indians who served in the war (should) be given the full rights of citizenship..." In 1924, the organization held a "ceremony of appreciation" for American Indian veterans.<sup>81</sup> The Legion's sentiment, according

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"denounced cruelty," and "boasted" about their human property "much as the strictest father might boast of the prowess of a favored child." Eugene D. Genovese, *Roll, Jordan, Roll: The World the Slaves Made* (New York, New York: Random House, 1976), 71-73. John Inzer had a history of favoring segregation. In 1917, he wrote to his senator to share his feeling that if military camps were integrated, as the Secretary of War was proposing, "there will be blood shed and much of it... if Secretary Baker thinks he can have both races trained in the same camp, he will find out his mistake when it is too late." "Letter from John W. Inzer in Ashville, Alabama to John H. Bankhead in Washington, D.C.", September 6, 1917. John Hollis Bankhead papers, LPR49, Box 31, Folder: European War, 1914-1918 - Military officers - Universal service, 1917 August - 1918 January, Available through the Alabama History Education Initiative: <http://digital.archives.alabama.gov/cdm/singleitem/collection/voices/id/3805/rec/8>, Alabama Department of Archives and History, Montgomery, Alabama.

<sup>79</sup> The impulse to strip African Americans of the right to organize was widespread, and eventually led to a Supreme Court decision that black fraternal organizations had the right to exist. Ariane Liazos Theda Skocpol, Marshall Ganz, *What a Mighty Power We Can Be: African American Fraternal Groups and the Struggle for Racial Equality* (Princeton, New Jersey: Princeton University Press, 2006), 15.

<sup>80</sup> Pencak, *For God and Country: The American Legion 1919-1941*, 68-69.

<sup>81</sup> "Letter Re. Ceremony of Appreciation", 1924. Administration & Organization -- Post -- "class" -- Indian, The American Legion Library, Indianapolis, Indiana.

to one scholar, was reflective of a time of increased assimilation and popular respect for American Indians.<sup>82</sup>

The Legion's relationship with Asian Americans was more complex. In 1919, the organization demanded that "foreign born Japanese be forever barred from American citizenship" but Asian American veterans constituted a distinct category.<sup>83</sup> In the interwar years, Chinese American Legion posts were established in San Francisco and Honolulu, and a Japanese American post was founded in Los Angeles. As Lucy E. Salyer has shown, although the Legion was a vehement force for anti-immigration sentiment throughout the 1920s and 1930s, the organization supported the efforts of Asian Americans *veterans* who sought naturalization. The backing of veterans' groups helped ensure the 1935 passage of the Nye-Lea Act, which provided for the naturalization of Asian former service members.<sup>84</sup> Within less than a decade, however, even this conditional support was called into question: as anti-Japanese sentiments flared in the World War II years, the Legion revoked the charter of its Japanese-American post.<sup>85</sup>

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<sup>82</sup> Kristin Erica Lesak, "Soldiers to Citizens: World War I and the Acceleration of the American Indian Assimilation Process" (M.A., University of Maryland, 2002).

<sup>83</sup> The quote is from Josephus Nelson Larned, *The New Larned History for Ready Reference, Reading, and Research, Volume I* (New York, New York: J.J. Little & Ives Company, 1922), 303.

<sup>84</sup> The precise number of Asian American men who fought with the A.E.F. is difficult to ascertain, according to Salyer. The Selective Service, she notes, "classified 1,131 Chinese and 983 Japanese as "class I" aliens, eligible for the draft." In arguing for the passage of the Nye-Lea Bill, the Legion and other advocates pointed out that only a small number of people would be affected by the law. Lucy E. Salyer, "Baptism by Fire: Race, Military Service, and U.S. Citizenship Policy, 1918-1935," *The Journal of American History* Vol. 91, no. No. 3 (December 2004). For numbers of Asian American draftees and volunteers, see p. 854; for an account of the Legion's involvement in the passage of Nye-Lea, see p. 866-876.

<sup>85</sup> The move was met with letters of protest from individuals, religious organizations, and the War Department. "Correspondence". Administration & Organization -- Post -- "class" -- Japanese -- Chinese, The American Legion Library, Indianapolis, Indiana. For a general reference on anti-Japanese sentiment in the World War II years, see John W. Dower, *War without Mercy: Race and Power in the Pacific War* (New York, New York: Pantheon Books, 1986). Precise numbers of Asian Americans who served with the army in World War I are "difficult to determine," according to Lucy Salyer, but the Selective Service classified 1,313 Chinese and 983 Japanese as "class I" aliens who could be drafted. Some were eventually drafted and some volunteered. Salyer, "Baptism by Fire: Race, Military Service, and U.S. Citizenship Policy, 1918-1935," 852. On the Legion and Asian American posts, see p. 871-876

Women, like other minority groups, were seen somewhat as a class apart within the American Legion, but they fared better than others in winning favor in the organization. From the Legion's inception, women who were regularly commissioned in the U.S. Army, Navy or Marine Corps were eligible for membership. That included nurses, who were often referred to with reverence in Legion publications.<sup>86</sup> Indeed, the organization's official policies constantly noted the necessity of obtaining rights for "service men and women." Over time, all female posts were established in various locations.<sup>87</sup> In 1921, a report from the Legislative Committee to the annual convention noted: "your committee has not been unmindful that women as well as men who served in the Great War are eligible to (*sic*) the benefits of hospitalization, compensation and vocational training." Approximately 34,000 women served "with the colors," the report pointed out, about 600 of whom were receiving post-service government compensation, and 240 of whom were in private hospitals. "Your committee has recommended that the best type of hospital care be provided in private hospitals for these women," the report said. The declaration was not quite as egalitarian as it may have seemed; the call for care in "private hospitals" demonstrated that the Legion felt that women ex-service members should have access to different, if not fewer, privileges than men. By 1921 – the year of the report – the organization often pointed out the shortfalls of private institutions, and was fighting strenuously for the establishment of more government hospitals, so that (male) ex-service members could be treated in institutions controlled solely by the Veterans' Bureau.<sup>88</sup>

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<sup>86</sup> See, for example, Carol Bird, "The Army Nurse Explains; Hard to Come Back to Civilian Patients after Serving Men Who Took a Wound as Part of Day's Work " *The American Legion Weekly* March 12, 1920.

<sup>87</sup> Regarding all-women posts in Wisconsin, for example, see George E. Sweet, *The Wisconsin American Legion: A History, 1919-1992* (Milwaukee, Wisconsin: Wisconsin American Legion Press, 1992), 32, 111.

<sup>88</sup> "Report of the Committee on Rehabilitation to the Third Annual Convention of the American Legion, Kansas City, Missouri, November 1, 1921". Rehabilitation Reports, The American Legion Library, Indianapolis, Indiana. The issue of private versus government hospitals is discussed further in Chapter Six of this dissertation.

Legion leadership was divided on the issue of granting access to the organization for women who worked with the military branches in non-commissioned roles.<sup>89</sup> In September 1920, individuals representing women who had served as secretaries, laboratory technicians, dieticians, anesthetists, and reconstruction aides pleaded with the organization to endorse their efforts to obtain some degree of status within the military, as opposed to being viewed merely as civilian employees. By extension, they would be eligible for membership in the American Legion, and the privilege of eligibility for a bonus. Lucy Chamberlain's call for Legion support demonstrated that women, like other minorities, recognized the necessity of making a passionate case to the all-powerful veterans' organization and the potential weight of its stamp of political approval. She drew applause at the Legion's second annual convention in September 1920 with an urgent plea:

I defy any one to tell me how you can call a woman who has taken the oath of enlistment who has a discharge, who is AWOL if she is off her job six hours without leave, a civilian employee... I ask the American Legion which is the only body of men we can appeal to (we served with you; you are the logical people for us to come to) to get behind this thing and attain for us a definite military status.

Miss McKeever from Pennsylvania shared a similar view: "I went over as a matter of service; I thought I could do something," she said. "I didn't go to either see France or learn the language."<sup>90</sup> At the 1921 annual convention, pleas like those of McKeever and Chamberlain led Representative Davis, of Pennsylvania, to propose that since "secretaries, dieticians, and technicians took the oath of allegiance, were paid by the Quartermasters' Department of the United States Army and wore the prescribed uniform... were subjected to the same discipline

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<sup>89</sup> For more on the role of women in the military during World War I, their struggle for military rank, and their status as veterans, see Chapter Two.

<sup>90</sup> "Proceedings, Second Annual Convention of the American Legion, September 27-29, 1920, Hotel Hollenden, Cleveland, Ohio", 125. American Legion Complete Minutes of National Conventions, The American Legion Library, Indianapolis, Indiana.

and enjoyed the same privileges and received the same discharges as did the Army Nurse Corps,” the AL should recognize them as eligible for full membership in the organization. The proposal was referred to the Legion’s National Executive Committee for consideration.<sup>91</sup> Because such women were admitted to the army as civilian employees, rather than commissioned personnel, they faced an uphill battle. If the Legion admitted them as full members, it would be setting the precedent that any civilian employee could join, thereby calling into question the exclusivity of the organization.<sup>92</sup>

The issue of whether women and other civilians who had not served, but still hoped to join the Legion arose even before the organization’s first convention. When, in June 1919, Executive Committee members discussed the formation of the AL Women’s Auxiliary, the community service bastion for wives, mothers, sisters, and daughters of veterans, they made clear their beliefs regarding the potential benefits of bringing women into the fold of the organization. “The local posts are going to need the refining influence of women,” said one Executive Committee member in June 1919. Women’s involvement, said Legion Commander Franklion D’Olier, would “strengthen very materially the formation of posts in certain towns.”<sup>93</sup> If the American Legion was a family affair, and women in communities were making their way

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<sup>91</sup> "The American Legion, 1921 National Convention Verbatim Minutes, October 31, 1921", 292-93. The American Legion Library, Indianapolis, Indiana.

<sup>92</sup> The Legion and other veterans’ organizations have traditionally not accepted as members those involved in war efforts as civilians. Benjamin R. Beede, "The American Legion," in *Encyclopedia of the Veteran in America*, ed. William Pencak (Santa Barbara, California: ABC-Clio, LLC, 2009), 58. See Chapter Two for more on women’s roles in World War I. As noted there, repeated attempts by women to gain fuller access to benefits finally bore fruit six decades after the war; in 1977, occupational therapists, Signal Corps operators, clerks, and hospital dieticians who served between 1917 and 1919 were finally recognized as veterans. Lettie Gavin, *American Women in World War I: They Also Served* (Niwot, Colorado: University Press of Colorado, 1997), 118.

<sup>93</sup> "National Executive Committee, Minutes of Meeting, June 9, 1919", 116-36.



to meetings, they could encourage their male counterparts to do the same.<sup>94</sup> In fact, D'Olier suggested opening up membership in the auxiliary to "members of draft boards, state militia not inducted into federal service, and others interested in the American Legion." Chaplain Inzer added that the few "old soldiers left" are "just simply crazy about us," and the Legion should encourage them to remain loyal to the organization, but the Committee's first order of business had to be the establishment of the American Legion itself, which should be limited to soldiers who served in the Army, Navy, or Marines in the current war. Mr. Price argued that if membership – even in an auxiliary – were opened as D'Olier suggested, "Legion members will think there are other organizations coming in to which they are very much opposed." All present seemed to agree that, for the time being, women relatives of full members should be the only people to whom auxiliary membership was open. There was little to lose, according to Chaplain Inzer. "An auxiliary member has no authority in the American Legion," he pointed out. Plus, welcoming them would "get the country solidly back of us... because these women are wonderful things."<sup>95</sup> In fact, the Legion Auxiliary that was born in this era became "one of the largest women's organizations in the United States," one that not only led a variety of fruitful community service efforts, but also played a crucial role in helping to publicize and gain support for enhanced benefits for disabled veterans.<sup>96</sup>

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<sup>94</sup> Legion Representative Squires, of South Dakota, even argued that all women, not just those related to soldiers and veterans, should be allowed to join the Auxiliary. "First Annual Convention of the American Legion, Minneapolis, Minnesota, November 10, 11, 12, 1919", p. 9, Nov. 11 evening session. American Legion Complete Minutes of National Conventions, The American Legion Library, Indianapolis, Indiana.

The auxiliary was referred to as "the Legion's big sister, not to mention its mother, its wife..." "Women's Auxiliary Looks Ahead", *The American Legion Weekly* August 19, 1921.

<sup>95</sup> "National Executive Committee, Minutes of Meeting, June 9, 1919", 116-36.

<sup>96</sup> The quote is from Beede, "The American Legion," 69.

Women veterans and male veterans of color attempted to establish a place for themselves in the American Legion and other like-minded organizations, but were often shunned. The organization's leadership – albeit, in some cases, hesitantly – placed concern for the loyalties of white, male members above the priority of fulfilling the tenets of the Legion constitution, which stated that all veterans were to be treated equally. Members of minority groups remained fiercely civically engaged in their own advocacy organizations, but few groups had the political clout – or the ear of as many members of Congress – as did the Legion.<sup>97</sup> It follows that the veterans' hospital system, which was shaped, in part, by the American Legion, was less accessible to minorities than it was to white men.

*“That power of winning the audience to his side”: The Disabled American Veterans and Robert Marx*

Although the American Legion might have been the most politically powerful veterans' group to emerge after World War I, others were also instrumental in raising awareness of the plight of injured and ill ex-service members. At the first convention of the Disabled American Veterans in June 1921 at the Detroit, Michigan Chamber of Commerce, the organization's National Commander addressed a packed house, and explained the group's ideological origins. “During the long years to come, while the paths of the able-bodied service men may tend to diverge,” Robert Marx said, “the life paths of the disabled men will run closer together.”

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<sup>97</sup> According to Skocpol et. al., “between the early 1800s and the mid-twentieth century, dozens of African American fraternal federations emerged and flourished...” See Theda Skocpol, *What a Mighty Power We Can Be: African American Fraternal Groups and the Struggle for Racial Equality*. On African American involvement in the war effort, and the government's interaction with and reaction to black troops and advocates, see Mark Ellis, *Race, War, and Surveillance: African Americans and the United States Government in the United States Government During World War I* (Bloomington, Indiana: Indiana University Press, 2001). For a more general reference on African Americans' contributions to the war effort, see Arthur E. Barbeau and Lorette Henri, *The Unknown Soldiers: Black American Troops in World War I* (Philadelphia, Pennsylvania: Temple University Press, 1974).

In the hospital, the disabled man received the public sympathy to which he is justly and generously entitled. In addition he has the protection of the institution, the friendly visitation and good advice. His wound heals. He leaves the hospital but his disability continues. He loses the protection of the institution, the friendly and the helping hand. He is still disabled but in the public imagination, he is now one of them and must shift for himself. Through an association such as ours, the needs of this man are met, the comradeship, the friendly advice and the helping hand continued...

The DAV, Marx said, would perform “the social service side of rehabilitation” by helping members work through a “tangle of red tape” to secure medical treatment, compensation, and vocational training.<sup>98</sup> An increasing number of veterans were attracted to the message in the early 1920s: in 1921, the DAV had 17,486 members; by early 1924, membership had grown to more than 44,200.<sup>99</sup>

A barometer of major causes and lesser-known eccentricities of his time, Robert Marx was a fortuitous choice as the DAV’s first spokesman. He was a successful lawyer and judge, a proud ex-service member, and an articulate and instrumental Democratic Party standard-bearer. Indeed, Marx’s political connections helped the DAV find its national footing in the early 1920s. From the DAV, Marx gained visibility as a prominent war-wounded veteran, which could be a professional and political asset. A pillar in the Midwest legal community, Marx was involved in some landmark cases of his time; in one of the most famous libel lawsuits in American history, he helped Aaron Sapiro, who was briefly his law partner in the mid-1920s, elicit an apology from auto tycoon Henry Ford for making anti-Semitic remarks in his *Dearborn Independent*

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<sup>98</sup> "Proceedings of the First National Convention of the Disabled American Veterans of the World War, at the Chamber of Commerce, Detroit, Michigan", June 28-30, 1921, 22. Proceedings of National Conventions, Copy held by author, Disabled American Veterans National Headquarters, Cold Spring, Kentucky.

<sup>99</sup> Membership in the DAV ranged from about 23,000 to approximately 48,000 throughout the 1920s and 1930s before jumping to more than 100,000 after World War II. "Membership by National Commander Terms". Special thanks to Rojean Long, secretary in the DAV membership department, for providing access to this document (copy held by author). Disabled American Veterans, National Headquarters, Cold Spring, Kentucky.

newspaper. He was also instrumental in establishing compulsory auto insurance as law.<sup>100</sup> Of German-Jewish descent, Marx's secularism did not preclude him from speaking publicly about the contribution of American Jews to the war effort. At the same time, he declared himself American before Jewish; he was outwardly opposed to the idea of Zionism and a Jewish state.<sup>101</sup> Marx was a loyal subscriber to fitness magazines, and spent his spare time pursuing wrestling, mountain climbing, "hand-balancing" – the practice of holding his own or another man's body weight while posed in a physically challenging position – and other hobbies that promoted health and well-being.<sup>102</sup> While Marx was a firm believer in the power of exercise and other forms of what could be construed as self-help, as the DAV's first National Commander, he also tirelessly argued that the U.S. government had an obligation to provide material support for wounded veterans. A bachelor until his death in 1969, Marx lived well – he traveled widely and had multiple vacation homes – but he thought beyond himself and created a rich personal legacy. In

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<sup>100</sup> For correspondence related to no fault auto insurance, see "No Fault Auto Insurance Correspondence and Clippings". Robert S. Marx Papers, Box 2, Folder 13, Cincinnati Historical Society Library Cincinnati, Ohio. Marx referred to the Ford case in a 1926 letter to Franklin D. Roosevelt: "Letter from Robert Marx to Franklin D. Roosevelt Re. Ford Case", 1926. Robert S. Marx Papers, Box 1, Folder 21, Cincinnati Historical Society Library, Cincinnati, Ohio. For background on the Ford case, see Victoria Saker Woeste, "Insecure Equality: Louis Marshall, Henry Ford, and the Problem of Defamatory Antisemitism, 1920–1929" *Journal of American History* Vol. 91, No. 3(December 2004).

<sup>101</sup> In February 1917 Marx declared, "I am too passionately American but I cannot comprehend the advantage of a Jewish state in Palestine to an American Jew. No government is so capable and none so willing to protect its citizens regardless of creed as our own... America is my legally secured home... it is my own – my native land..." "Extract from Address in Opposition to Zionism, Delivered by Robert S. Marx, before the Cincinnati Zionist Society", February 7, 1917. Robert S. Marx Papers, Box 6, Volume 11 scrapbook, clipping from *The Jewish Community*, Vol. 1, No. 3 Cincinnati Historical Society Library, Cincinnati, Ohio. Also see: Robert S. Marx, "Speech Regarding Contribution of American Jews to U.S. Wars" 1928. Robert S. Marx Papers, Box 2, Folder 11, "Addresses and speeches" Cincinnati Historical Society Library, Cincinnati, Ohio.

<sup>102</sup> "Collection of *Strength and Health* Magazines and Pamphlets on Hand Balancing". Robert S. Marx Papers, Box 3, Cincinnati Historical Society Library, Cincinnati, Ohio.

his will, he left substantial portions of his fortune to universities, libraries, and the veterans' organization he helped launch to national prominence.<sup>103</sup>

Robert Marx's passions were rooted in his upbringing. Within a year of his birth in 1889, his parents, William and Rose, re-located from an apartment above a shop in downtown Cincinnati to the upscale suburb of Avondale. Marx's father, William Marx, a successful shoe salesman, had connections and ambitions in the Democratic Party. In 1906, his friend and frequent lunch date, Cincinnati Mayor Edward J. Dempsey, appointed him president of the Board of Public Service. William Marx's service in that post ended abruptly when he accused his fellow Board members of "prejudice." But he was remembered, upon his death from cancer in 1915, as boasting a "kindly genial disposition, a quick, active mind, and a splendid executive ability..."<sup>104</sup>

Some of the same traits were recognized in Robert Marx as early as high school. A member of the debate club and the football team, the 1906 Walnut High School yearbook noted that he had "oratorical qualities which fill the rest of his classmates with pride," and "that power of winning the audience to his side."<sup>105</sup> In 1910, Marx was admitted to the Ohio Bar and began

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<sup>103</sup> "Last Will and Testament of Robert S. Marx", 1955. Robert S. Marx Papers, Box 1, Folder 3, "Clippings, obituaries", Cincinnati Historical Society Library, Cincinnati, Ohio.

<sup>104</sup> William Marx's political savvy and connections may have influenced his decision to reach out to a local congressman to help guarantee the safety of his son, who was in Europe when war broke out in 1914. Congressman Alfred G. Allen assured the elder Marx that he would attempt to secure a spot for Robert on one of two army transports bringing Americans back to the US in the summer of 1914. "Letter from Congressman Alfred G. Allen to William Marx", August 14, 1914. Robert S. Marx Papers, Box 1, Folder 10, Marx, William S., Cincinnati Historical Society Library, Cincinnati, Ohio. Correspondence to and from William Marx reveals his political involvement. In 1905, he was invited to the Conference of Democratic Candidates and to serve on the Democratic Campaign Committee of Hamilton County. In the same year, he was also the Cincinnati candidate of the Citizen's Municipal Party, and nominated for the Board of Public Service. "Letters to William Marx", 1905. Robert S. Marx Papers, Box 1, Folder 12, miscellaneous, Cincinnati Historical Society, Cincinnati, Ohio. Also see William Marx's obituary: "William Marx Obituary," *The Cincinnati Enquirer* March 3, 1915.

<sup>105</sup> Quoted in Charles L. Westheimer, "Biography of Robert S. Marx" October 1974, 11. Robert S. Marx Papers, Box 1, Folder 1, Cincinnati Historical Society Library, Cincinnati, Ohio.

making a place for himself as a prominent member of his community. He became involved in various civic organizations, and helped establish an Americanization program meant to encourage immigrants to assimilate.<sup>106</sup>

Not quite thirty years old when the United States began recruiting troops for the Great War, Marx eagerly answered the call. In the winter of 1916-17, he served as chairman of a local enrollment committee, which aimed to enlist Cincinnatians to attend training at U.S. military camps. Marx himself completed a naval training cruise aboard the Battleship Illinois in the summer of 1916 and was sworn in as a second lieutenant in August 1917. Assigned to the 357<sup>th</sup> Infantry, 179<sup>th</sup> Brigade, at Camp Travis in Texas, he was appointed senior instructor in physical training and the regimental athletic officer.<sup>107</sup>

Marx was shipped overseas in July 1918 as a Captain with the 357<sup>th</sup> Infantry, which participated in some of the most vigorous battles of the U.S. war effort. He exercised strict discipline with his troops, even while expressing veneration for them. The 357<sup>th</sup>, George von Roeder notes, was especially active: the signing of the Armistice on November 11, 1918, he says, “ended 75 days, except 7 for the changing of sectors, that the Regiment was under fire. With the exception of 48 hours, the Regiment was in the front line this entire time.”<sup>108</sup>

Even in the trenches, Marx proudly recalled after the war, “I required every man to shave himself every day, as nothing does so much to increase morale as a clean shaven company of

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<sup>106</sup> "Biographical Sketches of Robert S. Marx", 1959-1960. Robert S. Marx Papers, Box 1 Folder 2, Cincinnati Historical Society Library, Cincinnati, Ohio. For further reference to Marx's involvement in Americanization programs, see "Something About Citizen Marx," *The Cincinnati Post* October 31, 1919.

<sup>107</sup> On Marx's involvement with the enrollment committee, see "Concerted Effort Being Made to Secure Adequate Representation...", February 25, 1916. Robert S. Marx Papers, Box 1, Folder 12, Cincinnati Historical Society Library, Cincinnati, Ohio. For Marx's own description of his war service, see "Robert S. Marx, Autobiography". Robert S. Marx Papers, Box 4, Mss 903, vol. 1-5, Cincinnati Historical Society Library, Cincinnati, Ohio.

<sup>108</sup> Sgt. George von Roeder, "Short History of the 357th Infantry, <http://www.90thdivisionassoc.org/90thdivisionfolders/Mervinbooks/357/35701.Pdf>."

men.” He also mandated that trenches be “kept clean.” “Clean shaven faces and clean trenches are bound to promote clean rifles and clean ammunition,” Marx declared. “Added together, the whole creates pride, confidence, and spirit.”<sup>109</sup> He and other veterans’ group leaders would employ a similar rhetoric of pride in service and high expectations and standards in the post-war years.

Like other officers of the professional middle class, Marx’s reverence for the enlisted man was couched in a Progressive Era sense of classism, but it was also heart-felt.<sup>110</sup> “The mere private, the insignificant doughboy is the one man who should be worshiped by every American at home or abroad in or out of the army,” Marx wrote to his mother in October 1918. “Nothing is too good – nothing ever can be too good for the boy who has fought in the front line infantry in France,” he said. Still, Marx said it was important not to “pity” the soldier. He “eats well – he has three blankets – he gets his mail – his daily newspaper – splendid hospital and first aid service when wounded – everything that can be done for him... is done.”<sup>111</sup>

Marx soon experienced that hospital and first aid service for himself. In the closing hours of the war, he was stationed with his battalion in the small village of Baalon in northeastern France, when a barrage of German shells began dropping “with alarming accuracy.” He never heard the one that eventually struck him; he only knew he was hit in the head. Fighting the urge to faint, Marx attempted to walk himself toward medical assistance, but found himself unable. After the war, he recalled:

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<sup>109</sup> "Robert S. Marx, Autobiography".

<sup>110</sup> See Chapter Two for accounts from army doctors and nurses serving abroad regarding the heroism of enlisted soldiers.

<sup>111</sup> The quote is from a letter Marx wrote to his mother on October 24, 1918. Quoted in: "Robert S. Marx, Autobiography".

I sat down and ten minutes later, men came with the stretchers. The only thing I know of the trip back is that it was equally as dangerous as the advance had been. Every foot of the way was through a shell swept area. The number of gas shells used was so large that the stretcher-bearers had to put my gas mask on in spite of all my head wounds. I did not suffer so much, but that I could not help marveling even in that state, at the courage of the men who persisted in carrying me back three long kilometers without regard to the peril or danger to them.<sup>112</sup>

Alfred Segal, a columnist for the Cincinnati Post, saw Marx soon after his injury, and described his legs and arms as being “peppered with high explosives,” and generally, “quite a wreck.” He had 14 wounds, Segal reported, including a skull fracture and “gaping hole(s) in his shoulder and neck.”<sup>113</sup>

As a result of his injuries, Marx experienced a variety of the medical care facilities available to U.S. troops. His first stop was at a regimental first aid station for an anti-tetanus serum. From there, he was transported by ambulance to the 90<sup>th</sup> Division triage station at Sun-Sur-Meuse, and finally to a mud-floored mobile hospital at Verannes, where he received an operation and “hovered between life and death.” “When I became conscious, it was November twelfth,” Marx later recalled. “I asked how soon I could go back to my outfit; the doctor answered: ‘no hurry boy, the war is over.’” Soon after the injury, Marx reported to his mother that his wounds were “all from shell fragments but no vital parts are affected. I have some flesh wounds in my shoulder and in my arms which are rapidly healing and some scalp wounds which are steadily improving.”<sup>114</sup> By the time Marx was finally discharged six months later, he had experienced “delightful” American Red Cross hospitals and “most unpleasant and unsatisfactory” base hospitals in France, as well as “comfortable” convalescent hospitals in New

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<sup>112</sup> Ibid., 210-14.

<sup>113</sup> "The Story of Robert Marx," *The Cincinnati Post* October 29, 1919.

<sup>114</sup> See letter from Robert Marx to his mother, dated December 18, 1918, from Paris, France, in "Robert S. Marx, Autobiography".



York and New Jersey.<sup>115</sup> As Marx recovered from his wounds, his fellow patients made a powerful impression on him: "... the legless, the armless, the lungless (*sic*), the sightless," he later reflected. "To them the war was barely begun, for their suffering and sacrifice were just commencing."<sup>116</sup>

Before Marx was discharged from the army in May 1919, Cincinnati's local newspapers heralded his service and endorsed him for election as a judge in the city's superior court. His victory as a Democrat in an otherwise Republican-dominated race in November 1919 was a testament to the political power of a battle injury overcome and a "gallant military record."<sup>117</sup> In the lead-up to the election, Marx's proponents regarded him as a "most excellent soldier" whose efforts as a Captain "contributed no little to the glory of the brigade... and the ultimate victory of our army."<sup>118</sup> His "fearlessness," they said, had "been tested" and he had "proved himself of the courageous stuff public officials, especially judges, should be made of."<sup>119</sup> "This is your first chance to honor a service man with your vote..." a newspaper advertisement by the local

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<sup>115</sup> Ibid. For more details regarding Marx's whereabouts during service and following his injury, see "Discharge Certificate for Robert S. Marx". Robert S. Marx Papers, Box 7, Volume 13, Cincinnati Historical Society Library, Cincinnati, Ohio.

<sup>116</sup> Robert S. Marx, "Memorial Address, Armistice Day, Delivered at Emery Auditorium" November 11, 1920, 14-21. Robert S. Marx Papers, Box 2, Folder 11, Addresses and Speeches, 1920, 1928, n.d., Cincinnati Historical Society Library, Cincinnati, Ohio.

<sup>117</sup> According to one editorial, Marx's "gallant military record, his able leadership in civic affairs and his recognized ability as a lawyer say more for him than any words of ours can." "Cincinnati Post Editorial Endorsement", 1919. Robert S. Marx Papers, Box 6 mss 903, Volume 11, Cincinnati Historical Society Library, Cincinnati, Ohio.

<sup>118</sup> "Letter from Dan Morgan Smith to Editors of Cincinnati Newspapers", April 4, 1919. Robert S. Marx Papers, Box 7, Vols. 13-14, Cincinnati Historical Society Library, Cincinnati, Ohio.

<sup>119</sup> "Cincinnati Post Editorial Endorsement". According to a newspaper advertisement: "Judge Chas. J. Hunt, former Republican City Solicitor and a Judge of the common pleas court wrote of (the Democrat) Marx: "the zeal, patriotism and bravery shown by you in behalf of your country in the American army in France, in which service you were so severely wounded, exemplify qualities which are needed on the bench and should not be forgotten by your fellow citizens." "Robert S. Marx Indorsed by Republicans and Democrats", 1919. Robert S. Marx Papers, Box 6, Volume 11 scrapbook, , Cincinnati Historical Society Library, Cincinnati, Ohio.

Soldiers and Sailors Committee said. “He fought for us over there; let’s vote for him over here!”<sup>120</sup> In the end, Marx’s slim margin of victory was attributed to the unflagging support of fellow veterans. His election made it clear that when former soldiers stood by their “comrade,” their power was immense.<sup>121</sup>

### *The DAV finds its voice*

The particulars of the story of the founding of the DAV are recounted in various ways. According to one account, a group of disabled veterans gathered at the American Legion National Convention in 1919 and “discussed the need for an organization to represent the disabled veterans, and concentrate on their particular needs.” Following that meeting, Marx “invited a hundred men for dinner and discussion,” then, within a few weeks, “asked that a committee be formed to work with him in charting the organization’s beginning.”<sup>122</sup>

The most careful, detailed, and credible account of the organization’s formation is found in a 1926 letter and sworn affidavit from fellow veteran and Ohio native, Charles C. Quitman, who enlisted in 1916 and served as a stretcher-bearer in at least two major battles of the World

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<sup>120</sup> The group announced that it would have a “noonday meeting... to further the candidacy of Robert S. Marx.” “Newspaper Advertisement from Soldiers and Sailors Committee”, 1919. Robert S. Marx Papers, Box 6, Volume 11 scrapbook, Cincinnati Historical Society Library, Cincinnati, Ohio.

<sup>121</sup> “Marx’s victory over Gibson,” a local newspaper reported, “was attributed to the soldier voters standing by a comrade. Marx had a splendid military record and was seriously wounded when fighting in France. His race largely was made upon this record, and the soldier boys responded to the call by overcoming Republican majorities of more than 20,000... and pushing him over the goal by a small but sufficient majority.” “Gibson Defeated by Marx,” *The Cincinnati Enquirer* November 5, 1919.

<sup>122</sup> “First Commander Recalls Early Years”. Documents regarding DAV History, Box 54, undated clipping from DAV Magazine, Disabled American Veterans Headquarters, Cold Spring, Kentucky. For a similar account, see “History of the Beginning of the Disabled Veterans”. Documents regarding DAV History, Box 54, Disabled American Veterans Headquarters, Cold Spring, Kentucky.

War.<sup>123</sup> According to this version of the story, in the spring of 1920, shortly after Marx was elected as a judge, Quitman approached him in the locker room of the Cincinnati Gym and Athletic Club, where both men were members. Quitman and other students from a University of Cincinnati vocational education class were organizing a meeting with fellow disabled veterans from the Ohio Mechanics Institute on April 27, 1920, he told Marx. They hoped he, as a prominent and respected wounded veteran, might be willing to address the group. Marx agreed to speak about the necessity of an organization whose sole focus would be to represent the needs of disabled veterans. By May 1920, the group had met three times to discuss possibilities and goals, eventually drawing more than 200 disabled veterans from Ohio and neighboring states. As interest in the cause became clear, Marx helped draft a constitution and by-laws for an organization that would henceforth be called the Disabled American Veterans of the World War.<sup>124</sup>

Through Marx's leadership, the burgeoning group gained ideological and political legitimacy and national recognition. Marx helped spread the word about the growing Midwest-centered organization during an August 1920 cross-country train trip with Democratic

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<sup>123</sup> Charles Quitman enlisted in June 1916 and was discharged in April 1919. During the war, he served as a stretcher-bearer during battles at Meuse-Argonne and Ypres-Iys. On Quitman's war record, see Ohio Soldiers, Sailors and Marines, World War, 1917-1918: Accessed at Ancestrylibrary.com, 13821. Although Quitman lived with his father and mother in Cincinnati, Ohio upon returning from the war, by 1930, he had moved to San Diego, CA and become an attorney. Fourteenth Census of the United States, 1920, (Washington, D.C.: Bureau of the Census, 1920). Fifteenth Census of the United States, 1930, (Washington, D.C.: Bureau of the Census, 1930).

<sup>124</sup> Charles C. Quitman, "History of the Formation of the Disabled American Veterans, Sworn Affidavit" January 23, 1926. Documents regarding DAV History, Box 54, Disabled American Veterans Headquarters, Cold Spring, Kentucky. In 1954, frustrated that Marx was receiving credit for having founded the DAV, Quitman reiterated his claim that he and others had established the group, but that Marx was "responsible in a large measure for the rapid development of the organization." A recent history of the DAV seconds Quitman's account: Frustrated with the government's lack of services, it says, a group of disabled Cincinnati veterans sought help from "better-known disabled soldiers" in order to "make their voices heard." Richard E. Patterson; David W. Gorman; Thomas L. Wilborn; David E. Autry; Gary Weaver; Thomas K. Keller, *Wars and Scars: The Story of Compassion and Service for Our Nation's Disabled Veterans; a History of the Disabled American Veterans* (Accessible via internet: <http://www.dav.org/about/History.aspx>: Disabled American Veterans).

Presidential candidate, Ohio Governor James M. Cox and aspiring Vice-President, Franklin D. Roosevelt. While Marx's main focus on the trip was to help the Democrats gain veteran backing, he also used the 32-state tour as an opportunity to address local groups of disabled veterans and try to bring them into the fold of a national organization. In the process, Marx successfully solicited an endorsement from Governor Cox, who referred to the DAV as "the right kind" of organization.<sup>125</sup>

He was also able to convince Franklin D. Roosevelt, to send "a telegram of greeting and good wishes" to the DAV convention the following year. "I hope," FDR wrote, "you will keep together and work together until the debt of gratitude has been paid to the lowliest among you."<sup>126</sup> In his correspondence with Roosevelt, Marx represented himself as a sort of temporary head of the DAV – more of a fellow political operative than an advocate. "For the moment I am the national president of this association, known as the Disabled American Veterans of the World War," Marx wrote. "May I suggest that the delegates would sincerely appreciate a telegram of greeting and good wishes from you to be read at the convention."<sup>127</sup> Marx's correspondence with Roosevelt – the two remained in touch at least through the early 1930s – is especially notable given F.D.R.'s efforts in his early presidency to scale back veterans' benefits.<sup>128</sup>

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<sup>125</sup> Cox's assessment was contained in a personal letter to Joe Tumulty, President Woodrow Wilson's personal secretary, requesting that Tumulty see to it that Wilson transmit a message to the DAV Convention. "Letter from James M. Cox to Robert Marx, Containing Correspondence with Joe Tumulty", January 10, 1921. Robert S. Marx Papers, Box 1, Folder 17, Cincinnati Historical Society Library, Cincinnati, Ohio.

<sup>126</sup> "Telegram from Franklin D. Roosevelt to Robert S. Marx", June 27, 1921. Robert S. Marx Papers, Box 1, Folder 17, Cincinnati Historical Society Library, Cincinnati, Ohio.

<sup>127</sup> "Letter from Robert S. Marx to Franklin D. Roosevelt Re. Endorsement at National Convention", June 14, 1921. Robert S. Marx Papers, Box 1, Folder 17, Cincinnati Historical Society Library, Cincinnati, Ohio.

<sup>128</sup> For more on the latter, including helpful secondary sources, see the Postscript of this dissertation.

As the Disabled American Veterans of the World War gained members and garnered publicity, its leaders identified several key goals – more and better hospitals, reality-based vocational training, an adequate employment program, just compensation, social services for disabled veterans – and employed rhetoric similar to that of the American Legion in order to fight for them.<sup>129</sup> They simultaneously trumpeted sentiments of entitlement and anti-dependence. In this way, Marx and fellow advocates echoed and validated the fundamental ideals of government reconstruction efforts, even as they argued the latter were falling short of expectations. In September 1920, about 100 disabled veterans from Ohio, Kentucky, and Indiana nominated the DAV's officers and proclaimed their determination to “assist disabled soldiers and suppress efforts to exploit public sympathy.”<sup>130</sup>

Robert Marx, the organization's now popularly elected chairman, was candid about his belief that self-improvement and self-reliance should be a cornerstone of every veteran's return to civilian life. His outside interests in strength training and his reverence for bodybuilder Bernarr MacFadden, who deplored “weakness,” helps illuminate the fact that he did not support anything that could be construed as dependency.<sup>131</sup> Veterans' advocacy, in Marx's eyes, was a means of fostering independence and strength. The main goal of the DAV, he told the gathering,

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<sup>129</sup> "National Commander Issues First Message to Disabled Comrades," *Disabled American Veterans Weekly Magazine* July 22, 1922.

<sup>130</sup> "Disabled Veterans Form Organization", September 5, 1920. Robert S. Marx Papers, Box 7, Volume 13, newspaper clipping, Cincinnati Historical Society Library, Cincinnati, Ohio.

<sup>131</sup> Marx's personal papers contain a collection of health and fitness magazines. See Robert S. Marx Papers, Box 3, Cincinnati Historical Society Library, Cincinnati, Ohio. A short biography of Marx notes that he maintained a friendship with Bernarr MacFadden. Charles L. Westheimer, "Biography of Robert S. Marx" October 1974, 53. Ibid. Box 1, Folder 1,

was “to inspire in its members a determination to come back and to take their place in the nation as self-supporting and independent citizens.”<sup>132</sup>

Marx was careful to separate the organization with which he was affiliated from those that had a reputation for radicalism. When it came to the DAV, he said, there would be “no politics, no promises to redeem, no axes to grind.”<sup>133</sup> Board member, H.E. Michaels emphasized similar points. The DAV was not intended, he said, to “make unreasonable demands” on the government, but instead “to give (the disabled veteran) an opportunity to speak for himself.”<sup>134</sup> *Stars and Stripes*, the military’s newspaper of record, validated the group’s mission: “So many organizations have undertaken to aid the wounded and disabled in various ways that an expression from these men... would be watched with great interest.”<sup>135</sup>

The young organization took as a cornerstone edict the idea that disabled veterans were entitled to certain medical and educational benefits. Instead of having other groups plead their case, DAV officials said, disabled veterans should “determine for themselves what they want.” By banding together in a group, they would be better able to access “advantages” to which they were rightfully entitled, such as education and medical services.<sup>136</sup> The DAV prided itself on holding the government accountable for making good on its promises. “The community,” Marx said at the DAV’s first annual convention, needed to “pay its obligations” to wounded

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<sup>132</sup> "Disabled Vets to 'Come Back'," *Chattanooga New* June 28, 1921.

<sup>133</sup> "Disabled Vets Turn to Talk", June 26, 1921. Robert S. Marx Papers, Box 7, Vol. 13, newspaper clipping, Cincinnati Historical Society Library, Cincinnati, Ohio.

<sup>134</sup> "Red Tape Is Attacked in Detroit," *Cincinnati Enquirer* June 26, 1921.

<sup>135</sup> "Disabled Group Names Detroit for Convention," *Stars and Stripes* April 16, 1921.

<sup>136</sup> "Heroes' Session". Robert S. Marx Papers, Box 7, Vol. 13, undated newspaper clipping, Cincinnati Historical Society, Cincinnati, Ohio; "Disabled Veterans to Convene". Robert S. Marx Papers, Box 7, Vol. 13, undated newspaper clipping, Cincinnati Historical Society Library, Cincinnati, Ohio.

soldiers.<sup>137</sup> That obligation, advocates argued, was substantial. “Why should our boys be sent to the insane asylums and make no discrimination as to ex-soldiers, no special treatments to try and restore their minds,” asked Mayme A. Rock in a telegram to the DAV’s first convention. Rock’s brother, John, was being treated in a state asylum in Phoenix, Arizona. “Why,” she wanted to know, couldn’t “the boys mentally afflicted have special hospitals to care for them properly?”<sup>138</sup>

At the same convention, Rabbi Michael Aaronsohn, who, after being blinded in battle, attended rabbinical school, and then become the DAV’s chaplain, voiced a contrary opinion, one that was somewhat rare in the veterans’ activism arena. He argued that disabled veterans had to see themselves as part of a larger group of civilians with disabilities. “The war wounded have been peculiarly favored with the care of a generous and wealthy government,” he told the DAV’s first annual convention. “However, we must not overlook those about us who are similarly crippled or handicapped by the loss of some member or organ of the human body.”<sup>139</sup> In a later memoir, Aaronsohn shared poignant impressions of being blinded in war and subsequently living with a disability. And he voiced beliefs that were likely held, but rarely shared, by other war-wounded ex-soldiers. Why, he wondered, were disabled soldiers and veterans more venerated than those who escaped with no injuries? Aaronsohn expressed gratitude for the care offered him in military and other publicly funded institutions following his injury, but he also argued that the American government was misguided by the idea that blind people should be educated in institutions specifically for people with no sight. After all, he noted, they would have to work

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<sup>137</sup> "Proceedings of the First National Convention of the Disabled American Veterans of the World War, at the Chamber of Commerce, Detroit, Michigan", 22.

<sup>138</sup> Ibid., 57.

<sup>139</sup> Ibid., 76.

with sighted people for the rest of their lives.<sup>140</sup> Aaronsohn's perspective highlights the idea that, in more ways than one, not all disabled veterans saw themselves as a class apart.

In general, however, groups like the DAV and American Legion fought for policies that bolstered the idea that they were just that. The DAV's ability to publicize the plight of wounded veterans and make the problem visible was equally as important as its political and social work. Like the American Legion, the DAV had a variety of committees, including one focused on legislative issues, which lobbied members of Congress to support its agenda. It also boasted a social service arm – a liaison between individual disabled veterans and the government entities intended to serve them. In addition, the organization ran summer camps and other programs that provided a forum for socialization between wounded and ill ex-soldiers. These functions had a pronounced and direct effect on the lives of many veterans.<sup>141</sup>

But it was the DAV's ability to bring together apparently vulnerable ex-soldiers en masse, and draw abundant press coverage, that allowed the organization to have a wide-ranging *public* impact. When veterans from around the country attended the DAV's second annual convention in San Francisco, for example, newspaper articles about the event trumpeted inspirational stories of individual attendees, and the cause of the organization. A *Tucson Arizona Star* headline read: "Vets will try to unravel red tape in federal bureau's work when they hold meeting." The "army of broken boys" gathering in San Francisco, the article said, "look to the government as a worthy son looks to a father."<sup>142</sup> The *Tacoma Washington Ledger* reported that

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<sup>140</sup> Michael Aaronsohn, *Broken Lights* (Cincinnati, Ohio: The Johnson & Hardin Company, 1946), See especially p. 284-92.

<sup>141</sup> For a helpful summary of DAV activities in these years, see Keller, *Wars and Scars: The Story of Compassion and Service for Our Nation's Disabled Veterans; a History of the Disabled American Veterans*.

<sup>142</sup> "Veterans Will Try to Unravel Red Tape in Federal Bureau's Work When They Hold Meeting," *Tucson Arizona Star* June 22, 1922.



four local veterans would attend the DAV meeting; in fact, Merwin Stewart, who had lost both his legs, would drive the car.<sup>143</sup> The *Santa Barbara News* noted that a veteran named Charles G. Galloway, who had his leg amputated below the knee following an injury during the Battle of Belleau Wood – a “badge of honor,” the story said – was passing through town as he made his way from San Antonio, Texas to the convention in San Francisco. “Galloway is a merry-appearing youth,” the *News* reported, “who even though he is minus a leg, appears to know how to get lots of real joy out of life.” Earlier in the week, five disabled veterans – two who had legs amputated and three with “severe scars,” had passed through Santa Barbara on their way to San Francisco from New York.<sup>144</sup> The *San Francisco Examiner* urged readers to “listen carefully” to the veterans gathering in their city. “They are a race apart,” the paper reported, “these men who have gone half the distance that separates the living from the dead, but returned.”<sup>145</sup> Likewise, the *San Francisco Bulletin* argued, “the most American thing in America is an American war veteran with a wound... He is the true American aristocrat...”<sup>146</sup> Headlines in newspapers from Utah to California echoed the sentiment: “City honors heroes of struggle”; “Heroes of war modest men”; “Disabled vets lack hospital care”; “Vets will further peace”; “Toll of war shown as veterans meet”; “Cut red tape in caring for war heroes demands disabled vet chef”; “U.S. handling of war insane unfair.”<sup>147</sup>

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<sup>143</sup> "Four Disabled Veterans Leave Tacoma for National Meeting," *Tacoma Washington Ledger* June 22, 1922.

<sup>144</sup> "Texas Veteran Hops into City on Long Hike," *Santa Barbara News* June 23, 1922.

<sup>145</sup> "Wards of the Nation," *San Francisco Examiner* June 26, 1922.

<sup>146</sup> "The Most American Thing in America...", June 26, 1922. Robert S. Marx Papers, Box 8, Vol. 16, newspaper clipping from the *San Francisco Bulletin*, Cincinnati Historical Society, Cincinnati, Ohio.

<sup>147</sup> "Various Newspaper Clippings", 1922. Robert S. Marx Papers, Box 8, Vol. 16, Cincinnati Historical Society Library, Cincinnati, Ohio.

The DAV – and the publicity surrounding its formation and events – introduced the general public to the stories of individual ex-soldiers. In a time of demilitarization and growing weariness with war-related funding, it helped bring a unified rhetoric to the plight and demands of disabled veterans that were widely appealing, or at least difficult to argue against. The *Vallejo Chronicle* summed up the idea in an article previewing the DAV’s San Francisco convention: “Such a convention in every city of the land would bring home to the citizenry of the country the debt we owe them.”<sup>148</sup>

### *The DAV, anti-radicalism, and veterans of color*

Even though the DAV was attracting more and more attention, members of Congress from both parties, when asked to approve a federal charter for the organization in the early 1920s, expressed skepticism about whether another veterans’ organization was necessary. John Newton Tillman (D-AR) and Earl C. Michener (R-MI) agreed that too many organizations were appealing for federal charters in the first place. As a case in point, they noted that a group of women had attempted to obtain a charter for a national business and professional women’s league. “There is no end to applications,” Tillman said. However, given the nature of the DAV’s mission, both acknowledged, “from a sentimental standpoint, it would be rather difficult to deny these crippled boys this privilege if they feel they should be put in a class by themselves...”<sup>149</sup> Other congressmen voiced the concern that recognizing another veterans’ organization could be redundant, and make it more difficult to legislate. After all, they wondered, wasn’t the recently incorporated American Legion the mouthpiece of veterans nationwide? Wasn’t that group

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<sup>148</sup> “Disabled Veterans”, *Vallejo Chronicle* June 24, 1922.

<sup>149</sup> Incorporation of Disabled American Veterans, Committee on the Judiciary, House Hearings, H.R. 216, Sixty-Seventh Congress, First Session, (Washington, D.C.: Government Printing Office, June 15, 1921).

already “covering the issues”? Why was a “separate and distinct organization to take care of the disabled... necessary”?<sup>150</sup> What if a legislative issue arose and the DAV and Legion disagreed? “Where are we at” if the American Legion advises members of Congress one way, and the DAV another, wondered Michener.<sup>151</sup>

In fact, disenchantment with the American Legion was a motivating factor for some to become involved with the DAV. Rabbi Michael Aaronsohn, the DAV chaplain, recalled in the early 1940s that soon after World War I, the Legion represented to him a “grand monopolization of patriotism.” “The arbitrary classification of men according to war service was,” Aaronsohn believed, “an affront to the loyalty and devotion of those who were not ‘privileged’ to bear arms.” In June 1921, Colonel Frederick Galbraith, the AL’s National Commander who was seen as a great advocate for the disabled, was killed in a car crash. At that moment, Aaronsohn said, “it seemed that those who came after Galbraith only promised whole-hearted devotion to the cause of the needy and afflicted at opportune occasions...”<sup>152</sup>

As the DAV sought federal support in 1921, public statements from other organization officials were quite different in tone. Indeed, it was a testament to the power of the American Legion that Robert Marx and others justified the righteousness of the DAV by noting that AL leaders supported its creation. The new group would not take political stances contrary to the American Legion, Marx noted. Making a politically powerful argument, he proclaimed that the granting of a charter was a matter of lending dignity to those disabled in war.

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<sup>150</sup> The first quote is from Joseph Walsh (R-MA). The second quote from Richard Yates, (R-IL). Incorporation of the Disabled American Veterans, Committee on the Judiciary, House Hearings, H.R. 216, Sixty-Seventh Congress, First Session, (Washington, D.C.: Government Printing Office, July 7, 1921).

<sup>151</sup> The DAV was finally incorporated nationally in June 1932. To Incorporate the Disabled American Veterans of the World War, Senate Report No. 823, Seventy-Second Congress, First Session, (Washington, D.C.: Government Printing Office, June 13, 1932).

<sup>152</sup> Aaronsohn, *Broken Lights*, 313-17.

DAV leaders also justified the necessity of the organization by arguing that it could help stanch radicalism and anti-government sentiments. The DAV, Marx said, could serve as a means of unifying disabled veterans in a group that Congress could be sure was “under the right leadership.” Marx’s fellow DAV leader, Ralph A. Horr, went a step further. One of the goals of the DAV, he said, was to keep members “out of other organizations that would amount purely and simply to the exploitation of the disabled men and result in embarrassment to the government.”<sup>153</sup> The fact that Horr was a devoted Republican and Marx, a devoted Democrat, demonstrates that DAV membership and leaders had a variety of political backgrounds.<sup>154</sup>

Horr and others who argued that anti-radicalism should be a priority of the organization justified the claim that veterans deserved publicly-funded medical services by juxtaposing ex-service members’ righteous patriotism against leftists’ supposed anti-Americanism. At the first DAV convention in Detroit, Horr told the crowd of approximately 1,000 that he had visited a hospital in Chicago, where a disabled veteran was in want of medical care, the lower part of his arm amputated and the upper part turning black. There were soldiers like him throughout the country, Horr reported to applause; they had problems the DAV had to “attend to” that were “almost political.” Immediately following his discussion of the Chicago hospital, Horr described various lingering threats; “German-speaking societies” in the U.S. and supposed radicals who were “in communication with the Soviet of Russia...” “We have problems to solve as disabled veterans of this great war,” he said, “that are national and international in their scope.” Fighting

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<sup>153</sup> Incorporation of the Disabled American Veterans, Committee on the Judiciary, House Hearings, H.R. 216.

<sup>154</sup> Horr ran for various political offices (to serve as a Republican Representative, Senator, and Mayor), winning a post only once, as a Representative to the 72<sup>nd</sup> Congress from 1931 through 1933. For more on Horr, see his Congressional biography: "Ralph Horr Congressional Biography, [Http://Bioguide.Congress.Gov/Scripts/Biodisplay.Pl?Index=H000793](http://Bioguide.Congress.Gov/Scripts/Biodisplay.Pl?Index=H000793)."

for enhanced rights for disabled veterans and taking a stand against radicals, Horr implied, were complementary missions.

He and fellow DAV members who favored a greater emphasis on surveillance of immigrants and suspected communist agitators gained enough support within the ranks of the organization to spur conflicts between attendees of the organization's meetings and members of the comparatively left-leaning Disabled Soldiers' and Sailors' League.<sup>155</sup> When a representative from the latter group, Mr. Bodine, visited a DAV meeting in May 1921 and criticized Robert Marx's praise of the government's Federal Board for Vocational Education, attendees shouted that he and his comrades were radicals, bolshevists, and troublemakers. As Bodine left the room, one newspaper reported, he shouted back: "'We are proud to be called Bolsheviks. Although we have not so many members as this association we will start a drive tonight to enlist all the 'radicals' we can find among the disabled veterans who want a square deal.'"<sup>156</sup> About a month later, Horr led a contingent of DAV members into a socialist convention in Detroit and announced that "the Americans who fought against a foreign enemy would fight as hard against enemies at home if the need should arise."<sup>157</sup>

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<sup>155</sup> "Proceedings of the First National Convention of the Disabled American Veterans of the World War, at the Chamber of Commerce, Detroit, Michigan", 80-83.

<sup>156</sup> Marx urged veterans to acknowledge the good work of the Federal Board, in addition to recognizing its shortfalls. "Marx Backs up Federal Board for Veterans", May 21, 1921. Robert S. Marx Papers, Box 7, Vol. 13, newspaper clipping, Cincinnati Historical Society Library, Cincinnati, Ohio. Regarding the confrontation with Bodine, see: "Injured Soldiers Clash in Meeting", May 16, 1921. Robert S. Marx Papers, Box 7, Vol. 13, newspaper clipping, Cincinnati Historical Society Library, Cincinnati, Ohio. "Soldiers' League Called Bolshevik... Assailed by Disabled American Veterans at Lively Meeting in Y.M.C.A.". Robert S. Marx Papers, Box 7, Vol. 13, undated newspaper clipping, Cincinnati Historical Society Library, Cincinnati, Ohio. "Rival Organizations of Disabled Heroes of World War Clash". Robert S. Marx Papers, Box 7, Vol. 13, undated newspaper clipping, Cincinnati Historical Society, Cincinnati, Ohio.

<sup>157</sup> "Disabled War Veterans' Convention", July 21, 1921. Robert S. Marx Papers, Box 7, Vol. 13, newspaper clipping from *The Evening Journal* of Albany, New York, Cincinnati Historical Society Library, Cincinnati, Ohio.

There were plenty of DAV members, including the organization's national leaders, who did not support Horr's inflammatory tactics.<sup>158</sup> Robert Marx and Michael Aaronsohn often emphasized the importance of fighting for rights for disabled veterans over engaging in political debates. But the publicity surrounding incidents like the run-in with suspected socialists helped the DAV, like the American Legion, gain an image as a protector of conservative American values. When such a group requested extensions of government entitlements, the latter seemed justified and rational, not radical.

Like the American Legion, the DAV was challenged by a variety of sensitive social issues: it faced questions not only regarding political ideology, but also the matter of whether to welcome into its ranks veterans of color. Many of the organization's officials from the northeast and Midwest strongly felt that the group should include all former service members, regardless of sex, ethnicity, or race. Rabbi Michael Aaronsohn's account of the first annual DAV convention in June 1921 in Detroit, Michigan, painted a somewhat idealized picture of a highly egalitarian organization, which promoted "the friendship of Christian and Jew, of nonbeliever and priest, of Republican and Democrat, of Indian and immigrant, of Negro and Caucasian..." and united them in "brotherhood."<sup>159</sup> At the same meeting, however, members shared laughs and applause after one delegate opened his speech about the necessity of land grants for veterans with a joke about a "darkey" who had spent his time in the army not in valiant frontline service, but cleaning stables. Like their American Legion counterparts, attendees also passed a resolution

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<sup>158</sup> In 1922, rumors surfaced that Horr was attempting to organize several states to break away from the D.A.V. and form their own organization. He vehemently denied the charges, but he nonetheless played a more muted role in the D.A.V. thereafter. "Proceedings at the Second Annual Convention of the Disabled American Veterans of the World War, Held at the St. Francis Hotel, San Francisco, California, June 26-June 30, 1922", 196. Documents regarding DAV History, Copy held by author, Disabled American Veterans Headquarters, Cold Spring, Kentucky.

<sup>159</sup> Aaronsohn, *Broken Lights*, 321.

urging that “foreign-born Japanese shall be forever barred from American citizenship” in spite of opposition from a member named O’Boyle, who felt it went beyond the DAV’s “sole object... to work for the welfare of the disabled, and nothing else.”<sup>160</sup>

Indeed, members like O’Boyle and Aaronsohn faced strong ideological opposition from their counterparts – many from the South and West –who were not only strongly anti-immigrant and anti-radical, but also staunchly segregationist. The proposed policies of the latter group prevailed at the June 1922 annual convention in San Francisco, California, when three black veterans from Fairview, Texas were denied seats after travelling across half the country in order to attend. The incident prompted National Commander Marx to announce that, like the American Legion, the DAV’s official policy would be to allow state departments to determine whether black veterans would be recognized as members. Marx noted that the Fairview men had, in fact, been granted a chapter charter by the national body before the Texas state department was functioning, but the handing down of the state’s whites-only policy meant that charter would be revoked.<sup>161</sup> The organizational constitution, adopted at the annual convention in Detroit in 1921, explicitly said that state departments and local chapters could “admit or reject any applicant for reasons satisfactory to such State department or local chapter.”<sup>162</sup>

Although veterans of color were discriminated against in the DAV, and the organization was far from egalitarian, it was more accepting than some other groups of its time. Eventually, a “national chapter of colored members” was created within the DAV; by the early 1930s, state

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<sup>160</sup> "Proceedings of the First National Convention of the Disabled American Veterans of the World War, at the Chamber of Commerce, Detroit, Michigan", 65.

<sup>161</sup> "Negroes from Texas Rejected Because Charter Revoked", June 28, 1922. Robert S. Marx Papers, Box 8, Vol. 16, newspaper clipping from *The San Francisco Call*, Cincinnati Historical Society Library, Cincinnati, Ohio.

<sup>162</sup> "Proceedings of the First National Convention of the Disabled American Veterans of the World War, at the Chamber of Commerce, Detroit, Michigan", 49.

and local chapters were urged to refer membership requests from eligible African Americans to National Headquarters, so they could be passed on to that unit.<sup>163</sup> And Jews (including Robert Marx and Michael Aaronsohn) assumed positions of leadership. Occasionally, Marx even used his perch as National Commander to promote the idea that – contrary to the beliefs of some – American Jews were proud patriots.<sup>164</sup>

### Conclusion

The background of the establishment of a federal hospital system for veterans cannot be wholly understood without an examination of the role of veterans' groups in the contemporary political landscape. Groups like the American Legion and the Disabled American Veterans gained credence and political legitimacy in the months following the war by undermining efforts of less conservative groups at a point when public suspicion of leftist ideology was especially heightened, and simultaneously usurping aspects of their agendas. They helped to reinforce the long-standing belief that veterans were worthy of special reverence, and they worked closely with politicians to ensure they had the tools they needed to sponsor favored legislation. Disabled ex-service members, the groups argued, were the most worthy of all. While other issues such as veterans' bonuses and racial tensions divided membership of the Legion and the DAV, virtually

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<sup>163</sup> By 1933, the D.A.V. had created a "national chapter of colored members"; state and local chapters were urged to refer membership requests from eligible African Americans to National Headquarters, so they could be referred to that unit. "The Disabled American Veterans of the World War, Manual", 1934-1935, 14-16. Documents regarding DAV History, Unsorted files; copy held by author, Disabled American Veterans Headquarters, Cold Spring, Kentucky.

<sup>164</sup> "Jewish War Hero and Head of the Disabled American Veterans of the World War Thrills Audience", July 7, 1922. Robert S. Marx Papers, Box 7, Vol. 13, clipping from *Temple Emanu-El Newsletter* Cincinnati Historical Society Library, Cincinnati, Ohio. In the late 1920s, Marx connected the disproportionate part played by American Jews in the war effort with an attack on the anti-Semitic stories being printed in Henry Ford's *Dearborn Independent*. "The American Jew is but three per cent of the American population, and yet we furnished from four to five per cent of the Army, Navy and Marine Corps," he said. Marx, "Speech Regarding Contribution of American Jews to U.S. Wars".



everyone could agree that those who had been injured or become ill while serving deserved enhanced government-sponsored privileges, including free hospital care. Once that premise was widely agreed upon, veterans' groups propelled the political debate toward the issue of systemic change, and creating one government entity with concentrated power to oversee all veterans' benefits.

As veterans' groups found their footing and made the fight for the rights of ill and disabled ex-service members a cornerstone of their organizations, they served as willing allies for medical professionals and bureaucrats attempting to set the terms of the debate regarding veterans' hospital care. Legion and DAV representatives argued that veterans were not getting the quality of services they deserved and that the government should provide more funding. They maintained that ex-service members should not be treated in state facilities alongside other citizens. And they argued that they should have access to institutions close to their homes and families. Although they encountered skepticism from members of Congress regarding the necessity of these expensive measures, their agenda eventually prevailed; it formed the basis for the future of veterans' medical care.

## CHAPTER SIX

### **“One of the epochs of veteran relief”: Creating the Veterans’ Bureau and planting the roots of an autonomous veterans’ hospital system (1920-1921)<sup>1</sup>**

By the time the American Legion (AL) joined with congressional representatives to write legislation proposing the coalescence of all federal entities involved in veterans’ social assistance, government officials and professionals involved in the system were open to – indeed, desperate for – new ideas. It had been an arduous 18 months of attempting to coordinate disparate services of the army, Bureau of War Risk Insurance, and Public Health Service. In early 1921, thanks in large part to the influence of the American Legion, congressional debates surrounding the issue of medical care for veterans shifted from focusing primarily on temporary measures (the need for additional and better facilities in the short-term, for example) to the merits of more permanent and far-reaching legislation that mandated the creation of the Veterans’ Bureau, and the consolidation of government efforts to provide services.

Great tension existed surrounding the creation of a new welfare agency in a social and political climate that prized the ideal of self-reliance. Over a period of approximately nine months, between December 1920 and August 1921, the notion of establishing a distinct bureau for the management of veterans’ benefits went from being widely maligned, to being adopted as policy. The Veterans’ Bureau was approved in August 1921 because politically powerful advocacy groups were able to represent it not as a revolutionary agency that would oversee an array of new entitlements for a select group of citizens, but instead as the most cost-effective, efficient means of alleviating a dire, emergency situation. In its original form, the agency had

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<sup>1</sup> The quote is from Annual Report of the Director, United States Veterans' Bureau for the Fiscal Year Ended June 30, 1922, (Washington, D.C.: Government Printing Office, 1922), 6.

few vested powers when it came to structuring a national system of veterans' hospitals, but it had great potential for expansion.

Motivated by political expediency, social concern, or both, politicians of each of the major American political parties came to accept the idea that the situation surrounding medical care for veterans was untenable, and that sweeping change was necessary. Veterans' groups successfully kept the health problems of ex-soldiers in the public eye, and made it easy for policymakers to support their cause on a practical level; the American Legion authored multiple far-reaching bills concerning veterans' benefits, and thus handed congressional representatives the tools they needed to support and even promote the group's agenda. Veterans' advocates, with the support of bureaucratic "experts," not only negotiated millions of dollars in funding for the creation of hospitals and other resources, they also won the attention of, and occasionally, control over, governmental committees intended to decipher how the funding would be used. The creation of the Veterans' Bureau in August 1921, involving one central office in Washington, D.C. and 14 regional offices, put in place a systemic framework ripe for growth. At last, Congress had enacted policies that were not only favored by interest groups and government officials, but that would also shape soldiers' and veterans' medical care for the remainder of the century.

#### *A legislative turn toward systemic change: The Rogers Bill and political challenges*

John Jacob Rogers, veteran, American Legion member, and Republican representative from Massachusetts put forth the earliest legislative iteration of the Veterans' Bureau in December 1920.<sup>2</sup> A result of a three-day meeting of "high Legion officials with the chiefs of

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<sup>2</sup> As early as June 1920, a Congressional report noted that "the coordination necessary to secure speedy and efficient administration can only be secured by placing the three activities relating to the welfare of the soldiers of the late

various government bureaus,” the Rogers Bill contained a wish list of requests from the powerful advocacy group.<sup>3</sup> The extent to which the AL was responsible for its contents became clear when Rogers ceded conduct of the December 1920 congressional hearings pertaining to the bill to John Thomas Taylor, acting Chair of the Legion’s Legislative Committee.<sup>4</sup> Taylor comfortably assumed control, beginning by quoting from the Legion’s recent convention proceedings: “We cannot conceive of a greater accomplishment for the American Legion than the securing of the passage of a law which will unify the efforts of... the government agencies,” Taylor announced, referring to the veteran-related functions of the Federal Board for Vocational Rehabilitation, the Bureau of War Risk Insurance, and the Public Health Service. Abel Davis, the head of the Legion’s newly created hospitalization committee had written the bill, Taylor said, before the organization’s “good friend,” John Jacob Rogers, “perfected” it.<sup>5</sup>

The main function of the legislation was “consolidation at the top and decentralization in the field,” as Rogers put it.<sup>6</sup> The Bill would establish a “Bureau of Veterans’ Reestablishment,” in Washington, D.C. with one director who would oversee 14 or more regional offices. The

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war injured or diseased in the service under the same head.” Rehabilitation of Disabled Soldiers, House Report No. 1104 to Accompany H. Res. 495, Sixty-Sixth Congress, Second Session, (Washington, D.C.: Government Printing Office, June 4, 1920).

<sup>3</sup> The quote is from "Consolidation of U.S. Bureaus Plan of Legion’s Proposed Bill," *The Come-Back* December 4, 1920. Also see "For One Soldier Bureau; Bill Backed by American Legion Is Introduced in the House," *The New York Times* December 12, 1920. Rogers, who enlisted as a Private during the World War, was a member of the Legion. His wife, Edith Nourse Rogers, a member of its auxiliary, was elected to take her husband’s congressional seat upon his death in 1925. Known as a strong advocate for disabled soldiers during the war, she proved an ardent supporter of expanding veterans’ benefits during her more than 30-year tenure in Congress. Committee on House Administration; Office of the Clerk, "Women in Congress, 1917–2006," U.S. Government Printing Office.

<sup>4</sup> "Consolidation of U.S. Bureaus Plan of Legion’s Proposed Bill." Also see "For One Soldier Bureau; Bill Backed by American Legion Is Introduced in the House."

<sup>5</sup> Bureau of Veterans Reestablishment, Hearing before the Committee on Interstate and Foreign Commerce of the House of Representatives, on H.R. 14961, Sixty-Sixth Congress, Third Session, (Washington, D.C.: Government Printing Office, January 7, 1921), 6.

<sup>6</sup> *Ibid.*, 69.

organization would be charged with “treating all the necessities of the disabled man, whether that be hospitalization, compensation, or vocational training.” The suggestions, Abel Davis said, were based not on “any theoretical discussions with experts as to what is the way of handling problems of this sort,” but instead, on “practical knowledge” of veterans’ needs.<sup>7</sup> Legion officials were flexible about many particulars of the bill – the new entity did not have to be called the “Bureau of Veteran Reestablishment,” for example, and it did not have to be placed in the Department of the Interior – but there was one seemingly non-negotiable point: its director must have absolute authority over the Surgeon General of the Public Health Service and all other bureaucrats involved in veterans’ welfare.

Debates over the Rogers bill showcased some of the core issues connected with – and the primary arguments for and against – establishing a special government bureau intended solely to oversee the needs of veterans. Supporters of the bill cited various justifications for its passage. Although Congress had been generous with funding for ex-soldiers during the past three years, Abel Davis argued, it was relying on disparate entities to handle their treatment, compensation, and rehabilitation, which resulted in conflict and “passing the buck.” In other words, no one was fully responsible for fulfilling veterans’ needs, and therefore, no one was fully culpable for systemic shortfalls. The current bill, Rogers said, meant that there would be “some one whom we can hold individually responsible if things go wrong.”<sup>8</sup>

Then, there was the issue of money. Although the government might be over-spending, Legion officials argued, many veterans were not getting their due. If an ex-soldier enrolled in a FBVE training program, for example, he was eligible for compensation from that bureau, so he

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<sup>7</sup> Ibid., 8-15.

<sup>8</sup> Ibid., 80.

was taken off the rolls of the BWRI. But the latter organization was sometimes slow in transferring paperwork, so the ex-service man could go for months without receiving payment. Alternatively, in some cases, the government was paying double compensation because men were not taken off the BWRI roll before being added to the FBVE one, or vice versa.<sup>9</sup> Drawing on the latter point, Robert Marx, testifying both as a representative of the Legion's hospitalization committee and his new organization of disabled soldiers, the Disabled American Veterans, emphasized that the current bill was unique and worthy because it would, in fact, save the government money.<sup>10</sup> According to one 1920 estimate, the BWRI had made more than \$11,000,000 worth of overpayments to soldiers due to faulty communication between the BWRI, army, and Federal Board for Vocational Education.<sup>11</sup>

Centering authority in one bureau, advocates suggested, could enhance not only economic efficiency, but also coordination. Frederick W. Galbraith, the newly elected National Commander of the American Legion, argued that awards were all too unpredictable. He said he had recently visited a hospital where two men with the same disease were getting very different monthly payments – one, \$8, and the other \$80. The latter had been rated when his tuberculosis was at full force, while the former had been rated when it was arrested.<sup>12</sup>

Galbraith argued that passing the present bill would fulfill a duty, rather than constitute an expensive and questionable expansion of government. He reminded representatives that men were drafted into the army for the recent war, “without regard to their desire” and “accepted the

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<sup>9</sup> Ibid., 8-15.

<sup>10</sup> Ibid., 41-45.

<sup>11</sup> Hearings before the Subcommittee of the Committee on Appropriations, United States Senate, H.R. 13870, Sixty-Sixth Congress, Second Session, (Washington, D.C.: Government Printing Office, May 14, 1920), 23-24.

<sup>12</sup> Bureau of Veterans Reestablishment, Hearing before the Committee on Interstate and Foreign Commerce of the House of Representatives, on H.R. 14961, 27-40.

obligation willingly.” The government, he argued, “said to these men, when you are disabled... we pledge our national wealth and our sacred honor that you should be cared for...” Galbraith hinted at the next frontier of the Legion’s advocacy work for disabled soldiers, which was intimately connected with the current bill: the building of new hospitals solely for the use of veterans. Before the war, Congress had failed to mandate a hospital building program and now, he said, “men are still suffering.”<sup>13</sup>

The soldier who was in need of hospital care, said the Legion’s John H. Sherburne, “absolutely throws his hands up.” Instead of getting into a “terrific tangle of red tape” by attempting to access care at a government hospital, men were going to local charities for help.<sup>14</sup> Sherburne dramatically conveyed the gravity of the situation as he saw it, and the possible benefits of passing the bill: “The government today,” he said, “has the chance to salvage more human wreckage than they have ever had in a similar situation before.”<sup>15</sup>

Dr. Thomas Salmon, who had served as the Chief Consultant in Psychiatry for the American Expeditionary Forces and visited asylums, jails, and hospitals in 26 states, not only seconded the opinion that only a small percentage of soldiers who needed care had come forward to get it, but also that “divided authority” among various government agencies meant that “5,000 men who are suffering from insanity... are so poorly care for...” He reiterated Galbraith’s point that veterans and their families loathed the idea of seeking treatment for shell-shock and related diseases at state institutions, and that more hospitals were necessary specifically for ex-soldiers.

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<sup>13</sup> Ibid.

<sup>14</sup> Sherburne, a Brigadier General, was called a “principal founder of the Legion” by Edward D. Sirois and William McGinnis, *Smashing through The "World War"* (Salem, Massachusetts: The Meek Press, 1919), 175.

<sup>15</sup> Bureau of Veterans Reestablishment, Hearing before the Committee on Interstate and Foreign Commerce of the House of Representatives, on H.R. 14961, 21-26.

If institutions were built “for young men in full vigor,” Salmon said, veterans would not be in the embarrassing situation of having to receive care alongside the elderly and the poor, and they would “come out in number that will surprise you all.”<sup>16</sup> The statements of dire need found willing support among some of the representatives present. “I, for one, think it is about time that our Government established institutions to take care of these patients,” said John G. Cooper (R-OH).

As government officials involved in the Federal Board for Vocational Education, the Public Health Service, and the Bureau of War Risk Insurance – the three agencies that would be “unified” – testified against the rationale of various portions of the Rogers Bill, it became clear that although the legislation would constitute a major victory for the American Legion, it contained major flaws. Secretary of the Treasury, David F. Houston, argued that the Legion’s wish to eliminate delays was “very commendable,” but he called the notion of creating a new bureau, the head of which could be held fully responsible for veterans’ welfare “inadvisable and impractical.” First, he noted the breadth of the work of the Public Health Service, arguing that consolidating it with the Bureau of Veteran Reestablishment would “impair the efficiency of a governmental agency concerned in matters affecting vitally the entire population solely for the purpose of rendering service to... one group of people.” Furthermore, he hypothesized that such an organization “would not function satisfactorily,” and would fail to effectively serve both veterans and non-veterans alike. Houston seemed especially put off by the idea of placing the Surgeon General of the Public Health Service and its hospitals under the directorship of a “new bureau.” Such a transfer, he said, “would amount to a dismemberment” of the PHS. Instead of

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<sup>16</sup> Ibid., 53-57.



consolidation, Houston argued for an earlier iteration of the Rogers Bill, which would better coordinate the efforts of the Bureau of War Risk Insurance and the PHS under one head.<sup>17</sup>

Other government officials also implied that the legislation was too broad and sweeping. Before reassigning the job of veterans' welfare to a new agency, argued the Secretary of the Interior, Congress should investigate where efforts were being duplicated and address specific problems.<sup>18</sup> James P. Munroe, of the Federal Board for Vocational Education, was more explicit in his critique: "No facts have thus far been produced to show that any greater efficiency would be achieved, any more sympathetic consideration would be given to the disabled soldiers, or any more economical administration would result from combining the rehabilitation service with the other bureaus." Munroe joined the Secretary of the Treasury in his skepticism regarding whether current administrative problems could be solved by the "mere expedient of consolidation under a single officer." The FBVE's work was temporary in nature and was, "through experience, more efficient every day," he said, and to reassign its duties to "new and untried hands" would be both costly and "injurious to the disabled soldiers."<sup>19</sup>

Hugh S. Cumming, the Surgeon General of the PHS, concurred: far from serving to coordinate the workings of the three bureaus, the measure "absolutely disrupts the Public Health Service and its personnel, serves to destroy its carefully constructed corps of medical men, professional nurses, and other trained personnel..." "Confusion," Cumming said, would be the only result if the "ill-considered" Rogers Bill became law. Like the Secretary of the Treasury,

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<sup>17</sup> Ibid., 84-88.

<sup>18</sup> Ibid., 88. The Rogers Bill provided for the Bureau of Veterans' Reestablishment to be placed in the Department of the Interior, mainly because that department oversaw the administration of veterans' pensions and educational endeavors, such as Indian Schools and national parks. On the reasons offered by Legion representatives for placing the new bureau in the Department of the Interior, see p 33, 43-46

<sup>19</sup> Ibid., 89-92.

Cumming said he believed the three bureaus should be coordinated under one head, in one department, but that person should act as coordinator, not absolute authority. The heads of the FBVE, the BWRI, and the PHS, each had different areas of specialty, and no one director could be a “Poo Bah,” Cumming said. It was impossible “to gather together in one individual a doctor, a financier, and an educator.” Division of authority, he implied, was wholly necessary. Passing this “radical legislation,” Cumming said, would result in a disruption in administration and care for disabled service men.

The director of the Bureau of War Risk Insurance, Richard G. Cholmeley-Jones, seconded Cumming’s opinion that the PHS should run hospitals where veterans were treated, instead of turning over the responsibility to the Bureau of Veteran Reestablishment. In such an arrangement, the new bureau would oversee physical examinations of men before they were sent to hospitals, but once they arrived there, the PHS would have authority over their care.<sup>20</sup>

At the center of debates over the Bureau of Veteran Reestablishment (and later, the Veterans’ Bureau) was the question of whether the legislation would lead to the creation of a long-term federal hospital system for veterans. The “ultimate hope,” according to Abel Davis of the Legion, was that the PHS would cede control over hospitals where veterans were treated to a new Bureau of Veteran Reestablishment. But even as they advocated for the creation of a distinct veterans’ medical system, Legion officials attempted to assuage the fears of cost-conscious politicians. One congressman wondered whether a PHS “general” hospital system would eventually exist, and another system “exclusively for the service of ex-service men.” That was not a “necessary conclusion” of the legislation, according to Congressman Rogers, but “in the

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<sup>20</sup> Consolidation of Government Soldier Compensation Bureaus, Hearings before a Subcommittee of the Committee on Interstate and Foreign Commerce of the House of Representatives on H.R. 14677 and H.R. 14961, Sixty-Sixth Congress, Third Session (Washington, D.C.: Government Printing Office, February 14, 1921), 8-40.

main, and rightly, it would be the rule.”<sup>21</sup> The Legion’s assertion that a new Bureau of Veteran Reestablishment, not the PHS, should have authority over hospital facilities and care, which arose in legislative debates throughout the next year, represented more than just a stance on semantics and administration. The group was laying the groundwork for the argument that veterans should have their own autonomous federally-sponsored hospital system; that resources – funding and facilities – should be devoted to an organization solely for the benefit of former service members, not a pre-existing government agency focused on the needs of the greater population.

The Rogers Bill proved to be slightly ahead of its time. As Madeleine Edison Sloane, daughter of Thomas Edison, told *The New York Times*, it was ““killed in subcommittee, presumably because of the unwillingness of the officials of the existing boards to work under one director.”” Sloane neglected to note the concerns brought up by PHS and other officials regarding the legislation, and instead emphasized the ongoing plight of disabled and ill soldiers and veterans. ““Apple pies are no substitute for wooden legs,”” she lamented. There was “no coordination” among the government bureaus overseeing care for disabled soldiers, and now, Congress had failed to pass the Rogers Bill, the one viable solution to the problem.”<sup>22</sup> Sloane emphasized the issue of veterans’ neglect and the crisis at hand, rather than the more controversial questions brought up at the Rogers’ Bill hearings concerning the broader, potentially negative effects of creating a Bureau of Veterans’ Reestablishment.

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<sup>21</sup> Bureau of Veterans Reestablishment, Hearing before the Committee on Interstate and Foreign Commerce of the House of Representatives, on H.R. 14961, 81.

<sup>22</sup> “Public Help Asked for Veterans’ Bill: Plan for Federal Bureau of Rehabilitation Would Concentrate Relief Activities,” *The New York Times* March 20, 1921. ““Public Help Asked for Veterans’ Bill; Plan for Federal Bureau of Rehabilitation Would Concentrate Relief Activities””, *The New York Times* March 20, 1921.

"It will rest with the Government to determine their final use": A comprehensive system of hospitals for veterans, for the short-term

Soon after the failure of the Rogers Bill, in the closing hours of Woodrow Wilson's presidency, advocates and bureaucrats pushing for a more expansive hospital system won a major legislative victory. As Wilson "waited upon Congress in its final hour in his room off the Senate Chamber," one of the bills he signed into law was an \$18.6 million appropriation intended for the improvement, expansion, or building of hospital facilities and dispensaries for BWRI patients.<sup>23</sup> Public Law 384 – the so-called Langley Bill – stipulated that \$6.1 million could be used for the improvement of existing institutions, and the remainder for the construction of new facilities.<sup>24</sup>

The Langley Bill received a hearing and became a reality, in large part, because of a mighty fight on the part of the American Legion. The tale of the bill's long journey to the House floor demonstrates that veterans' legislation was often hard-fought. According to *The Come-Back*, the newspaper of Walter Reed Hospital, the Legion appeared before the Committee on Public Buildings and Grounds four times urging a favorable report on the Langley Bill, which, in its original form, provided \$10 million for hospitals to be used for BWRI patients. Just before the House adjourned in June 1920, the bill was favorably reported and placed on the calendar of the House. In December 1920, the Committee on Public Buildings and Grounds voted unanimously for the appointment of a subcommittee to secure a special rule from the Rules committee in order

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<sup>23</sup> The quote is from: "Many Important Bills Die with 66th Congress," *The Baltimore Sun* March 5, 1921.

<sup>24</sup> An Act Providing Additional Hospital Facilities for Patients of the Bureau of War Risk Insurance and of the Federal Board for Vocational Education, Division of Rehabilitation, and for Other Purposes, Public Law 384, H.R. 15894, 41 Stat. 1364, Sixty-Sixth Congress, Third Session, (Washington, D.C.: Government Printing Office, March 4, 1921).

to allow the bill to be brought before the House for a vote. The special rule was granted on January 11, 1921.<sup>25</sup>

The Langley Bill marked a turning point for several reasons. First, it was a *hospital* bill above all else, based largely on the requests of the Public Health Service, rather than the Director of the Bureau of the War Risk Insurance. Although both the BWRI and PHS were in the Treasury Department, previous legislation concerned with veterans' medical care had provided money directly to the BWRI, bringing about complaints from Public Health Service officials about a lack of control and access. It was impossible to plan a hospital program, they argued, when approval and funding for every project or idea had to be sought from an outside agency.<sup>26</sup> In passing the Langley Bill, legislators responded to this complaint. Senators and representatives who debated the bill cited as the basis for its contents the PHS Surgeon General's estimates regarding extent of need.<sup>27</sup> The passage of the Langley Bill indicated legislative acceptance of the claim that hospitals were an issue that needed to be dealt with on its own, rather than as part of a lump sum appropriation that covered other benefits as well.

The new law was also important because it took power for locating institutions out of the hands of representatives and senators. In its original form, the bill proposed that new hospital sites would be located based on the recommendations of a "commission composed of congressmen." According to Wesley L. Jones, (R—WA), the involvement of legislators in the selection of sites would "save the government a good deal of money." But a few of Jones'

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<sup>25</sup> "Measures for Aid of Vets Are Facing Congressional Jam," *The Come-Back* February 5, 1921.

<sup>26</sup> See Chapter Four for a further description of PL 246, which allocated \$46 million to the Bureau of War Risk Insurance and brought about a storm of protest from PHS officials.

<sup>27</sup> See, for example, United States Congressional Record, Senate, Sixty-Sixth Congress, Third Session, (Washington, D.C.: Government Printing Office, February 7, 1921), 2711.

colleagues spoke against such a provision. James W. Wadsworth (R—NY) argued that a commission ruled by congressmen and senators would “take months to bring about any decision.” Almost as a case in point, the Senate hearings soon devolved into a series of calls from senators for the Langley Bill to include funding for the enhancement of specific facilities in their respective states. “If we want to save time, if we want to do this thing effectively,” Wadsworth suggested, sites for new institutions should be chosen by the PHS, subject to the approval of the president.<sup>28</sup>

Democrats in both the House and Senate concurred with Wadsworth’s suggestion that representatives of the PHS and other medical experts had the best knowledge of what facilities were needed where, and that they should be left to autonomously decide the matter. Would a senator with “a sick friend or, unfortunately, an ill relative, consult a physician or four politicians?” asked Henry F. Ashurst (D—AZ).<sup>29</sup> Ladislav Lazaro, a Democratic representative from Louisiana and a doctor, made a similar argument in the House. Health professionals, Lazaro said, “who know how to treat those cases” should say “where they should be treated.” The “medical authorities who have charge of this money,” he suggested, “could select a commission composed of experts, especially in these tuberculosis cases, who would make a rapid survey and then decide where this money should be spent and where these boys should be treated.”<sup>30</sup> Lazaro’s idea was greeted with applause.

Debates over the passage of the Langley Bill also demonstrated that many had come to accept the idea that the provision of hospitals for veterans constituted a persistent need, one that

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<sup>28</sup> *Ibid.*, 2708-10. For the series of requests from senators to locate facilities in their own states, see p. 2711-2714.

<sup>29</sup> *Ibid.*, 2709.

<sup>30</sup> United States Congressional Record, House, Sixty-Sixth Congress, Third Session, (Washington, D.C.: Government Printing Office, February 7, 1921), 2734.

might not be adequately addressed by piecemeal annual allotments from Congress. In the House, discussions of the bill reached a high partisan pitch, with both Democrats and Republicans arguing that members of the other party were erecting barriers to treatment for needy and disabled war veterans. Democratic representatives resented the fact that the bill was introduced under a suspension of House rules, which meant that no amendments could be offered to the legislation; therefore, a representative (of either party) “who wants to go further and offer amendments so as to meet the whole problem by a broad constructive bill instead of the piecemeal bill is denied the opportunity to do so,” said Otis Wingo (D—AR). When Wingo offered his critique, the Langley Bill contained specific recommendations for hospital sites, which Democratic representatives claimed overlooked their party’s strongholds, and were politically motivated. Republican legislators, for their part, argued that Democrats were stalling, and that action on the present bill was necessary immediately.

Beyond the partisan bickering, representatives of both parties paid lip service to the same long-term vision. The Langley Bill represented “merely the beginning of a great hospital-building project, which may ultimately cost many times the amount authorized by this bill,” said John W. Langley (R—KY). Likewise, as Otis Wingo put it, Democrats were eager to write “broad” legislation that would “adequately take care of the hospitalization of our soldiers in every section of the country.”<sup>31</sup> The bill passed the House with 239 voting in favor of it and no members voting against it, indicating that even though Democrats disagreed with many of its core provisions, they would “vote to provide hospitalization for the soldiers...”<sup>32</sup> Like so many pieces of veteran-related legislation before and to come, congressional representatives voted

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<sup>31</sup> Ibid., 2731-33.

<sup>32</sup> Ibid., 2732. The vote tally is on p. 2736.

based on the principle behind the law – that former soldiers should have access to better hospital facilities – and not their judgments regarding its specific contents and logic.<sup>33</sup>

In the Senate, too, legislators acknowledged that the Langley Bill represented only the beginning of much more expansive provisions, though members of opposing parties differed as to what that meant for policy in the short-term. Joseph T. Robinson (D—AR) noted that the Surgeon General of the PHS had requested \$35 million, much more than the \$18.6 million allotted in the legislation. “If we only authorize the amount carried by the committee’s provision (the amount that could be spent within one year) we will never catch up with the requirements of the service or even approximate that accomplishment,” Robinson said. “The construction of permanent, suitable institutions,” he suggested, could not be accomplished within the confines of fiscal year appropriations. He estimated that it took five to six months to locate a site for a hospital, and even longer to secure “contracts, plans and specifications.” “If we wait and only make the authorizations now of such sums as will be actually expended during the coming fiscal year we will be no nearer up (*sic*) with the requirements of the service at the end that time than we are now,” Robinson said. Reed Smooth (R—UT) attempted to quell his colleague’s concerns. “I am positive that at the end of the year, when the next appropriation bills come up, or, if necessary, a bill carrying the amount outside of a regular appropriation bill before the appropriation bills pass... whatever is necessary to take care of hospitalization for the ex soldiers

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<sup>33</sup> Many concerns raised by Democrats in the House were alleviated following further discussions in the Senate. In its final form, the Langley Bill contained very few specific recommendations regarding where the appropriation should be spent, with the exception of three military forts, which were transferred to the Treasury Department via the law. An Act Providing Additional Hospital Facilities for Patients of the Bureau of War Risk Insurance and of the Federal Board for Vocational Education, Division of Rehabilitation, and for Other Purposes, Public Law 384, H.R. 15894, 41 Stat. 1364.



will be granted by Congress at any time.”<sup>34</sup> The Langley Bill was thus passed with the acknowledgement that it was both insufficient and necessary.

Public Law 384 was a relic of Wilson’s administration, but it would be executed under a new President, Warren G. Harding. Throughout his campaign, Harding sharply distinguished himself from his predecessor, guaranteeing Americans he would usher in a “return to normalcy,” lower taxes, and less government intervention. He won the accolades of veterans’ groups early on. In December 1920, the president-elect made time to meet at his home with his fellow Ohioan Robert Marx. Although the DAV chairman had campaigned eagerly for Harding’s Democratic presidential opponent, once the returns were in, Marx was able to note Harding’s virtues. The president-elect, he said, was “simple and democratic,” and “as plain as an old shoe.” He further reported that Harding had “a very keen understanding of the problems facing the disabled soldiers and sailors; a very sincere and heartfelt sympathy for them and a firm determination that they shall be the first charge and first duty of the nation as soon as he becomes president.”<sup>35</sup> Two weeks before he assumed office, Harding attempted to affirm this belief with a public statement: “I shall make it one of the first items of important business,” he said, “to see that the conditions affecting the government’s care of our disabled veterans are rendered more efficient.”<sup>36</sup>

To those ends, in the days immediately following the passage of the Langley Bill, Harding’s new Secretary of the Treasury Andrew W. Mellon appointed a board of medical experts to decide how to disburse the allocated money. The Consultants on Hospitalization,

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<sup>34</sup> United States Congressional Record, Senate, 2715-18.

<sup>35</sup> "Harding Will Help Disabled War Vets... President Elect Discusses Problem with Judge Robert S. Marx," *Cincinnati Enquirer* December 23, 1920.

<sup>36</sup> "Pershing Lauds Plan Extending Aid to Wounded," *The Come-Back* February 12, 1921.

referred to as the White Committee after its director William Charles White, was tasked with conceiving of a building program for hospitals that would serve veterans.

The committee took as its point of focus not only the recently passed Langley Bill, but also PL 326, which in 1919 authorized the Treasury Department and by extension, the PHS to take over a Chicago army hospital, establish a tuberculosis sanitarium at Dawson Springs, Kentucky, enlarge a Marine hospital in Stapleton, New York, and build new hospitals in Washington, D.C. and Norfolk, Virginia – all for the benefit of World War veterans. According to the White Committee, PL 326 “did not take into consideration at all the question of a consistent program for the complete hospitalization of the veterans of the world war; nor did it make any attempt to provide a hospital system in relation to centers of military population...”<sup>37</sup>

The White Committee was intended to right such previous wrongs and offer professional advice that was untainted by politics or greed as, it was understood, previous parties had been when proposing isolated hospital projects in certain districts.<sup>38</sup> The committee consisted mainly of nationally renowned experts on tuberculosis and mental illness, a nod to the two major health challenges facing the government in the long-term care of ex-soldiers. White served as medical director of a tuberculosis hospital in Pittsburgh and on the executive committee of the National Association for the Prevention of Tuberculosis, and, during the war, headed the tuberculosis unit of the American Red Cross in France. The Committee included as well Frank Billings, a past president of the American Medical Association, the Association of American Physicians, and the

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<sup>37</sup> "Delays in Hospital Construction, Conclusions", August 22, 1922. Records of Collaborating Boards and Committees, Board of Consultants on Hospitalization, General Correspondence and related records, 1921-23, Record Group 121, Box 27, Entry 164, National Archives and Records Administration, College Park, MD.

<sup>38</sup> See Chapter Four for more on PL 326, and early debates regarding political motives behind the location of veterans' hospitals. According to Rosemary A. Stevens, the White Committee “provided a useful transition in the veterans' hospital debates.” Rosemary A. Stevens, "The Invention, Stumbling, and Re-Invention of the Modern U.S. Veterans Health Care System, 1918-1924," in *Veterans' Policies, Veterans' Politics: New Perspectives on Veterans in the Modern United States*, ed. Stephen R. Ortiz (Gainesville: University Press of Florida, 2012).

National Association for the Study and Prevention of Tuberculosis. During the war, Billings served as head of the rehabilitation program of the Army Surgeon General and chairman of an American Red Cross mission to Russia. In the early 1920s, he was Dean of Rush Medical College. Pearce Bailey, and his eventual replacement, George Kirby were both psychiatrists. Another committee member, John G. Bowman, was a leader in the emerging field of hospital standardization, authoring in 1919 the first volume of the formative *Minimum Standards for Hospitals*. The group undertook detailed studies of available government-owned hospital beds, creating copious charts, reports, and maps describing its findings. Its members not only visited institutions themselves, but also interviewed the foremost experts on hospital and medical care for veterans and the greater population.

In a preliminary report released soon after the White Committee's founding, an advisory committee consisting of Thomas W. Salmon, Thomas B. Kidner, and Henry A. Pattison, of the National Tuberculosis Association, and Charles M. Pearsall of the National Home for Disabled Volunteer Soldiers, laid out a "comprehensive plan of hospitalization" for veterans with tuberculosis and mental and nervous diseases. (A separate report on the needs of general medical patients, the group explained, would subsequently be submitted.) The report noted that the \$18.6 million appropriation was hardly enough to solve the problem at hand, but contained concrete suggestions for providing enough hospital beds for veteran-patients. When it came to treating patients with mental diseases, for example, Thomas Salmon suggested that the White Committee plan for three distinct stages: a "relatively slow ascent," a "rather long level phase," and finally, a "slow descent." He recommended additions and improvements to four PHS hospitals in Pennsylvania, Maryland, Georgia, and Iowa, along with the building of several new institutions in the districts with the most limited resources and the highest ex-soldier populations, including

California, Illinois, Minnesota, and Colorado.<sup>39</sup> The White Committee drew attention to the fact that it was mindful of costs. In a list of issues “to mention to the President,” it noted that “with few exceptions,” many of the 6,000 beds it was planning to add to government facilities for the use of ex-soldiers would be “enlargements of government-owned properties.”<sup>40</sup>

The \$18.6 million allocated by the Langley Bill was granted to the Department of the Treasury and it was clear that the White Committee envisioned a hospital system that would serve veterans in the relatively short-term, but benefit a larger population – in Treasury Department facilities such as Public Health Service Hospitals – at a later date. “In locating these hospitals your consultants have had in mind the permanent value to the Government of its investment in these institutions,” said one Committee report. “It will rest with the Government to determine their final use.”<sup>41</sup> A “crisis expansion” of an expansive veterans’ hospital system, it was understood, would be short-lived; most of the resources it provided would be useful later for purposes other than providing medical care for a distinct population.<sup>42</sup>

That notion – and the White Committee’s determination to be efficient and results-oriented – was challenged by the August 1921 creation of the Veterans’ Bureau and that

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<sup>39</sup> "Preliminary Reports, Memo from the Advisory Committee to the Chairman, Committee on Hospitalization, Treasury Department", April 18, 1921. Records of Collaborating Boards and Committees, Board of Consultants on Hospitalization, General Correspondence and related records, 1921-23, Record Group 121, Box 25, Entry 164, National Archives and Records Administration, College Park, Maryland.

<sup>40</sup> The Committee assumed, for example, that more beds in Old Soldiers’ Homes would eventually come in handy “to take care of their necessarily increased work at a later period.” It also noted that it was “trying to place the institutions in such a way as to fit in with the plans suggested for a new department of welfare,” which will be discussed later in this chapter. "To Mention to the President", June 11, 1921. Records of Collaborating Boards and Committees, Board of Consultants on Hospitalization, General Correspondence and related records, 1921-23, Record Group 121, Box 27, Entry 164, National Archives and Records Administration, College Park, Maryland.

<sup>41</sup> Letter to the Secretary of the Treasury, Quoted in Report of the Consultants on Hospitalization Appointed by the Secretary of the Treasury to Provide Additional Hospital Facilities under Public Act 384, (Washington, D.C.: Government Printing Office, January 25, 1922).

<sup>42</sup> The term “crisis expansion” is used in "Preliminary Reports, Memo from the Advisory Committee to the Chairman, Committee on Hospitalization, Treasury Department".

agency's subsequent expansion of power. Within less than two years, the building program overseen by the White Committee in the Treasury Department would be subsumed under a brand new government organization – one with a director who was eager to maintain control of hospital construction and standards within his own bureau.<sup>43</sup>

*“So far as treating them in separate institutions, it is almost a necessity...”*

Local customs of segregation and reports from black soldiers that they were being poorly treated in government institutions complicated the question of how to structure a veterans' hospital system. Throughout the U.S. (in the north as well as the south) prior to the 1960s, three “architectural patterns” existed for hospitals where black patients could be admitted: the first was the all-black hospital; the second was the ““mixed-race hospital,”” where African Americans were separated from other patients, often in basements, attics, or separate wings. The third model, “rare even in the north,” according to scholar P. Preston Reynolds, was the integrated hospital, where all patients might be treated in the same building. But black patients often endured inferior conditions even in the latter institutions; wards housing white patients often had fresher paint, better nurse staffing, and more lenient visiting hours. Rules were different for white and black doctors, as well: white physicians could treat any and all patients, while black doctors were generally restricted to working only in units reserved for African Americans.<sup>44</sup>

Early wartime army policy went against these larger realities, (as well as the military's policy of segregation), and dictated that black and white soldiers would be treated in the same military hospital wards. But in March 1918, Army Surgeon General William C. Gorgas

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<sup>43</sup> "Delays in Hospital Construction, Conclusions".

<sup>44</sup> P. Preston Reynolds, "Professional and Hospital Discrimination and the U.S. Court of Appeals Fourth Circuit, 1956–1967," *American Journal of Public Health* Vol. 94, Issue 5 (May 2004).

mandated that because of tensions that arose in hospitals by virtue of integration, black and white soldiers should be separated in the institutions, so far as possible. Even in government hospitals where black troops and veterans were admitted and treated, they were often barred from social activities and full participation in educational programs.<sup>45</sup> Vanessa Northington Gamble points out that many southern communities refused to hospitalize black and white veterans in the same facilities. Some black veterans, in fact, were unable to receive any hospital care at all, or were placed in jails or mental institutions instead of medical institutions.<sup>46</sup>

As early as 1919, the Wilson administration responded to dissatisfaction among injured and ill black soldiers and veterans by assigning an African American lieutenant, J. Williams Clifford, as the “special representative of the Colored service men in the Bureau of War Risk Insurance.”<sup>47</sup> In that capacity, Clifford received telegrams and letters reporting “unjust, discriminating and cruel treatment that is accorded wounded heroes by medical examiners in certain United States government hospitals in the south.” When Clifford attempted to organize an investigation of one such institution – Camp Logan, in Texas – he said his efforts were “held up, it being claimed that such procedure would get the bureau into trouble.” After Clifford was directed “to send my dictated letters down to another office, where a white high school graduate

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<sup>45</sup> For a fuller description of the army’s policy of segregation in hospitals, the wartime care of black veterans, the protests that resulted, and helpful secondary sources, see Chapter Two of this dissertation. In planning for the post-war care of soldiers, Public Health Service and Bureau of War Risk Insurance officials sometimes deemed institutions unsuitable for white patients, but apropos for African Americans. See Chapter Four for details.

<sup>46</sup> Vanessa Northington Gamble, *Making a Place for Ourselves: The Black Hospital Movement 1920-1945* (New York; Oxford: Oxford University Press, 1995), 72.

<sup>47</sup> The title is as per Clifford’s own description: “Reports Prejudice in War Risk Work,” *The Chicago Defender* November 6, 1920. Clifford served in the 367<sup>th</sup> Infantry Regiment of the 92<sup>nd</sup> Division, which had enlisted ranks comprised entirely of African American soldiers. The 367<sup>th</sup> Infantry was considered by many to be “the most notable unit of the 92<sup>nd</sup> Division.” For more on both bodies, see Emmett J. Scott, *Scott’s Official History of the American Negro in the World War* (Chicago, Illinois: Homewood Press, 1919), The quote is on p. 190. On the 92nd and 367th, see 130-96.

approved and signed them, signing my own signature to my own letters before they were sent out,” he resigned in frustration.<sup>48</sup> It had been slightly more than a year since he assumed his federal post.

Following his departure, Clifford shared with the Associated Negro Press excerpts of the letters he received from black soldiers being treated under the auspices of the BWRI in Texas and Arkansas. Veteran S.H. Cavitt wrote from Houston, Texas to report that, “the doctors and nurses turn deaf ears to (black veterans’) pleadings.” Another former soldier, Lloyd Bates, wrote from Texarkana, Arkansas that he was a “cripple... unable to walk and work,” yet his compensation had been cut. “I want a new rating from some doctor who does not call us Nigger and make us wait two hours until all the whites are waited on.” Augustus Stansbury, of Dallas, Texas, reported that “it seems that all these white doctors here are giving us a raw deal they will not send in our medical reports so that we can get our compensation.” Theodore Roe, of Halley, Arkansas, reported a similar problem, adding, “We do know they will write to the Bureau for the white boys but not for us.” J.E. Davis, Y.M.C.A. secretary in Marshall, Texas, suggested that the problem was widespread. “Hundreds of colored people hereabouts in the State of Texas are being robbed, cheated, deprived of the things rightly due them from the Bureau,” he said.<sup>49</sup>

In addition to facing bureaucratic challenges, black soldiers and veterans also experienced segregation and violence in hospital wards. Black patients at Fort McHenry in Baltimore, Maryland, for example, reported that they were only allowed to use the Red Cross

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<sup>48</sup> "Reports Prejudice in War Risk Work." According to K. Walter Hickel, Clifford's resignation signified his dejection with the Wilson administration's refusal to challenge the precedent of segregation at the federal level. K. Walter Hickel, "Entitling Citizens: World War I, Progressivism, and the American Welfare State, 1917-1928" (Ph.D. Dissertation, Columbia University, 1999 ), 159-66.

<sup>49</sup> "Soldiers Cannot Get Insurance," *Afro-American* April 8, 1921.

reading room when white patients were eating dinner.<sup>50</sup> Segregation was practiced not only in the south, but in the north as well. At a Public Health Service hospital in Chicago, Illinois, a group of black patients complained that when the hospital sponsored a trip for patients to the theater, white patients were escorted in “touring cars and limousines” while black veterans “rode down in an ambulance.” These former soldiers wondered: “Haven’t we done as much and do we not deserve the same as the whites?”<sup>51</sup>

In February 1922, tensions peaked when a riot erupted between black and white veterans at the Edward J. Hines Jr. Memorial Hospital in Maywood, Illinois. The episode began, *The Chicago Defender* reported, when four white ex-soldiers knocked on the door of a room where six black veterans were gathered. ““We’re going to chase you out of here,”” said George Rice, one of the white men, to Charles Jones. “If you were in the South you wouldn’t be in any hospital at all,” added George Germain, another instigator. The fact that the white veterans were, in the end, discharged from the Public Health Service Hospital legitimized the *Defender*’s account, according to the newspaper, and showed that there was some limit to the government’s tolerance of racially motivated violence. Hospital Commander M.J. White told the *Defender* that there were 100 black veterans and 900 white veterans at the hospital and the “whites are the only ones who give the hospital attachés any trouble. The discipline of the Race men is exceptionally good.”<sup>52</sup>

The riot at Hines Memorial Hospital was just one clear demonstration that resistance to any semblance of integration was widespread and deep-seated. In March 1920, Adina de Zavalía,

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<sup>50</sup> "Wounded Men Still at Fort Mchenry," *The Baltimore Afro-American* April 21, 1922.

<sup>51</sup> Leroy J. Knox; Mitchell Adam; A.L. Howard; Mathew Reid; W.H. Banks; Thomas Stephens; Davie Taylor; Charles Mosley; Matthew Dunn; J.T. Smith, "Lest We Forget," *The Chicago Defender* November 6, 1920.

<sup>52</sup> J. Blaine Poindexter, "U.S. Probes Hospital Fight: Soldiers Discharged after Riot," *Ibid.* February 11, 1922.



“a Mexican, who now resides in San Antonio,” complained that “sick soldiers of both races are mixed indiscriminately in the base hospital at Ft. Sam Houston.” A representative of Zavalia claimed that, “irrespective of the record the soldiers made on foreign battlefield... the Southern Jim Crow law must be upheld.”<sup>53</sup>

The Disabled American Veterans took up a similar cause when its leaders presented to the Congressional House Committee on Public Buildings and Grounds a report lamenting the fact that white and African American veterans were treated in the same wards at Walter Reed. On ward 35, according to the report, there were “26 white men and two negroes,” a proportion mirrored closely in several other wards. The suggestion of separate treatment facilities was not meant to be an attack on black former soldiers, argued Frank J. Irwin, national rehabilitation chairman of the Disabled American Veterans. In fact, Irwin felt “they would welcome a change in policy as much as the white patients.”<sup>54</sup>

The deliberations of the White Committee highlight the fact that, while laying the groundwork for a national veterans’ hospital system, government officials were challenged by the question of how to provide for black men who sacrificed their health in service to nation, but who were still deemed unworthy of the privileges of full citizenship, let alone state-sponsored, modern medical care. In the spring of 1921, African American veterans with neuropsychiatric

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<sup>53</sup> “Protest Mixing Soldiers Sick in Army Hospital,” *The Chicago Defender* March 6, 1920. Zavalia’s stance highlights tensions that arose as the southwestern borderlands of the United States were patrolled by black troops during and after the Mexican Revolution of 1916. Gerald Horne argues convincingly that Zavalia’s was not the only, or even the predominant perspective; many Mexicans and African-Americans at the time, he shows, embraced the concept of “La Raza,” wherein Mexicans declared themselves as a single race that included a rich mix of African, Indian, and European elements. Gerald Horne, *Black and Brown: African Americans and the Mexican Revolution, 1910-1920* (New York, New York: New York University Press, 2005).

<sup>54</sup> “Investigation of Conditions at Walter Reed Demanded: Resolution Offered in House after Disabled Veterans Complain Whites and Negroes Are Treated in Same Wards,” *The Washington Post* Jan 23, 1924. The broader intention of the DAV’s congressional testimony was to voice opposition to the expenditure of \$900,000 of a \$6.5 million Veterans’ Bureau appropriation to improve hospital facilities at Walter Reed. Since the appropriation was intended for the VB, advocates said, it should be spent only on VB facilities. The Congressional hearings help reveal how jealously VB funding was guarded in the organization’s early years.

illnesses were treated in separate hospital units from their white counterparts in institutions in Mississippi and Louisiana, and in separate facilities entirely in Georgia, Alabama, and Texas, according to the White Committee's Dr. Thomas Salmon. The largest hospital located closest to the center of the African American veteran population on the border of Georgia and Alabama, was at Marshallville, Georgia. More than 4,000 patients were housed at that hospital, which Salmon referred to as a "very unsatisfactory" facility. One of the major disadvantages of treating white and black patients in the same institutions, Salmon said, was that white patients "will not work where the negroes are working." So, in southern hospitals, "all the (white) patients sit on the porch and the negro does the work, which is fine for the negroes but bad for the white patients, because there is no occupation for these agricultural people except farm labor." Since white veterans could not receive proper and full work training when housed and treated among their black peers, Salmon suggested, "I do not think there is any question but that they should be in separate institutions."<sup>55</sup>

Salmon further reported that African Americans were seeking hospital care at a much lower rate than white veterans. 4.4 white veterans per thousand were admitted to hospitals to be treated for tuberculosis, while only 2.1 per thousand black veterans were. The difference was even greater for the treatment of neuropsychiatric disorders, for which 5.1 of every thousand white veterans sought care, as opposed to 1.5 of every thousand black veterans. The great majority of African American veterans were likely aware that care at many institutions where they could be treated was, as Salmon put it, "very unsatisfactory." As black newspapers reported hospital riots and unequal treatment at the hands of the army and the BWRI, it is no wonder the

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<sup>55</sup> "Report of Conference Held in Offices of Consultants on Hospitalization, May 9, 1921", 63-64. Records of the Public Buildings Service, Record Group 121, Box 35, Entry 164, National Archives and Records Administration, College Park, Maryland.

former soldiers resisted willingly placing themselves in government facilities. But according to Salmon, the low admission rates among black veterans presented a major problem: "If they did not need hospitalization, that would not make any difference but somewhere the negro insane are a danger and they are much more liable to be a danger to white than to negro."<sup>56</sup>

In order to solve the "emergency problem," Salmon recommended moving forward with what he imagined would be a world premier "negro scientific institution" in Tuskegee, Alabama, where the highest concentration of black veterans could be found. His idea met with approval from fellow committee members. "I think it would be extremely unwise to put white and colored in one institution," said White Committee member and a fellow expert on psychiatric illnesses, Dr. George H. Kirby. "It seems to me that so far as treating them in separate institutions, it is almost a necessity," said C.H. Lavinder of the Public Health Service.<sup>57</sup>

Educator Alice Dunbar Nelson was one of many African American activists who voiced her support for the notion that ill and injured black soldiers should be treated in institutions intended solely for them. "It may be objected and is frequently a source of controversy that separate hospitals are non-essential," Dunbar Nelson wrote in 1919. But she argued that such reasoning was "idle and fallacious." Hospitals for African Americans, she said, "are needed in some places as schools, churches and social organizations are needed."<sup>58</sup> In New York and

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<sup>56</sup> Ibid., 65.

<sup>57</sup> Ibid., 64-66.

<sup>58</sup> Alice Dunbar-Nelson, "Chapter XXvii: Negro Women in War Work," in *Scott's Official History of the American Negro in the World War*, ed. Emmett J. Scott (Chicago, Illinois: Homewood Press, 1919).

Philadelphia, local groups undertook efforts to establish new hospitals for the treatment of African American soldiers and veterans, to be staffed by black doctors and nurses.<sup>59</sup>

Many felt that such institutions could serve as nexuses of black education and opportunity, but the National Association for the Advancement of Colored People (NAACP) and others balked at the proposal to locate the premier hospital for black veterans in the deep southern city of Tuskegee, Alabama, charging that doing so would further entrench customs of segregation and do a disservice to former service members.<sup>60</sup> “One needs only read both white and colored newspaper (*sic*) to find out how welcome the colored soldiers will be in that hell-ridden section,” one World War veteran wrote to *The Chicago Defender* newspaper. “Our newspapers and race organizations owe it to the Colored soldiers who were shot and gassed in France and maltreated on their return to America to take steps to see that this outrage is not consummated.”<sup>61</sup> The National Committee on Negro Veterans Relief and other organizations agreed. They argued that it was more important that a hospital for black veterans be located “near some recognized medical center,” rather than close to the center of the African American population. “We do not believe Alabama, or that general vicinity offers such a strategic location.” The committee argued that the “bulk of the probable cases” were not located near Tuskegee. Perhaps most importantly, according to the committee, “the men generally would

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<sup>59</sup> "Patriotic Meeting for Mcdonough Hospital," *The Chicago Defender* May 4, 1918. "Begin Mcdonough Memorial Hospital," *The Chicago Defender* June 15, 1918. "New Hospital for Colored Officers and Soldiers," *The Baltimore Afro-American* May 31, 1918.

<sup>60</sup> For a comprehensive description of the founding of the hospital at Tuskegee, see Gamble, *Making a Place for Ourselves: The Black Hospital Movement 1920-1945*, 72-104. Jennifer D. Keene, "The Long Journey Home: Federal Veterans' Policy and African- American Veterans of World War I," in *Veterans' Policies, Veterans' Politics: New Perspectives on Veterans in the Modern United States*, ed. Stephen Ortiz (Gainesville, Florida: University Press of Florida, 2012). Also, Colin Gordon, *Dead on Arrival: The Politics of Health Care in Twentieth Century. America* (Princeton, New Jersey: Princeton University Press, 2003), 179-82.

<sup>61</sup> "Forum: Does Not Want to Go South for Hospital Treatment Says Wounded Soldier," *The Baltimore Afro-American* August 5, 1921.

prefer to dispense with medical treatment altogether than to receive it at an institution in the proposed environment.”<sup>62</sup> Advocacy groups like the National Committee on Negro Relief believed a hospital for black veterans should be located near Washington, D.C.’s Howard University, a premier institute of higher learning for African Americans. They became even more hostile to the idea of locating a veterans’ hospital in the deep south when the Director of the newfound VB mandated in 1923 that although Tuskegee would be staffed by black professionals, whites would occupy the highest posts at the hospital. The move led to calls of injustice from advocacy groups, and black doctors’ refusal to work there.

After a protracted battle with local whites, African Americans achieved black control at the hospital. The NAACP and other groups who originally opposed the location of a hospital in Tuskegee lent their support to the institution only after President Warren Harding guaranteed that it would be staffed and run by black professionals. The accomplishment was deemed a major victory at the time, but later, some would argue that the existence of the Tuskegee institution actually retarded the desegregation of all veterans’ hospitals – a feat accomplished until the 1950s.<sup>63</sup>

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<sup>62</sup> "Ex-Service Men Want Hospital Located North," *The Baltimore Afro-American* November 4, 1921.

<sup>63</sup> For a contemporary account of the struggle to ensure that African-Americans would staff Tuskegee, see "To Oust Whites at Tuskegee," *The Chicago Defender* April 21, 1923. Vanessa Gamble presents a detailed account of the protracted fight to replace the hospital’s white staff with doctors, nurses, and administrators of color. Gamble, *Making a Place for Ourselves: The Black Hospital Movement 1920-1945*, 87-103. According to one scholar, veterans’ hospitals in the South began desegregating in 1950, thanks to a directive from the chief medical administrator of the Veterans’ Bureau, who felt that “if blacks were good enough to fight for their country they were also deserving of equal medical care. E.H. Beardsley, "Good-Bye to Jim Crow: The Desegregation of Southern Hospitals, 1945-1970," in *Readings in American Health Care*, ed. William G. Rothstein (Madison, Wisconsin: The University of Wisconsin Press, 1995). On hospital desegregation, also see David Barton Smith, "The Politics of Racial Disparities: Desegregating the Hospitals in Jackson, Mississippi," *The Milbank Quarterly* Vol. 83, No. 2(2005).

*Continuing the drive for consolidation: The Dawes Committee*

A few weeks after the first meeting of the White Committee, President Harding demonstrated his determination to show that he was fulfilling his campaign promises to veterans by convening a separate group of experts, this one less focused on a building program than on addressing and recommending ways for dealing with the general administrative problems facing disabled ex-soldiers seeking government benefits. "I should like you to make... an effort to find out just where the Government agencies are in any way lacking in authority, neglectful, or failing to carry out what is the unquestioned intent of the Congress..." Harding wrote in his letter establishing the "Committee to investigate the administration of the law in caring for the crippled and impaired soldiers of the late war." It was unquestionable, he said, that the government aimed to provide the best possible care for ex-service members, but he urged the group to help establish a "firm foundation" for the administration of veterans' benefits by examining past "abuses" and "regulations." After all, Harding presciently noted, "the policies adopted at this time are very likely to be in effect for a full half century to come."<sup>64</sup>

In the first week of April 1921, during three days of meetings of what became known as the Dawes Committee, representatives from the American Legion, the Red Cross, and organized labor questioned officials from the BWRI, PHS, and FBVE, and repeated many of the concerns expressed in hearings regarding the failed Rogers Bill. The group's head – banker and long-time Republican loyalist, Charles G. Dawes – stated his determination to remain focused on solutions,

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<sup>64</sup> Hearings before a Subcommittee of the Committee on Interstate and Foreign Commerce of the House of Representatives, H.R. 3, Part I, Sixty-Seventh Congress, First Session, (Washington, D.C.: Government Printing Office, April 29, 1921), See Exhibit No. 2, Letter from President Warren G. Harding to "General Dawes and members of the Committee," 44.

not problems.<sup>65</sup> “We know the conditions, and they are deplorable,” he said. “The thing is to find a remedy.”<sup>66</sup> Dawes’ determination prompted one author to argue, “the disabled American veteran in need of medical care has had no more effective champion in all of U.S. history than the fiery General Dawes.”<sup>67</sup> Dawes did maintain a tone of urgency that helped keep committee members focused, and ensured that discussions extended through meal times, and late into the evening. Still, he served primarily as a moderator, rescinding control of the proceedings to Col. Frederick W. Galbraith, National Commander of the American Legion.<sup>68</sup> Galbraith and other Legion representatives assumed control as easily as they had during the Rogers Bill hearings, taking occasionally contentious stances with government officials while covering topics ranging from compensation during vocational training, to methods of determining disability ratings.

During discussions, it became clear that several significant points of confusion and differences in opinion could not be immediately resolved. Charles Sawyer, President Harding’s personal physician, who was detailed to the committee as his “special representative,” wanted to

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<sup>65</sup> Dawes would later serve as Director of the Bureau of the Budget under Harding and Vice President of the United States under Republican President Calvin Coolidge. He also won a Nobel Peace Prize for conceiving of the 1924 Dawes Plan, an ultimately unsuccessful scheme intended to stabilize Germany’s economy. On Dawes, see John Erwin Pixton, “The Early Career of Charles G. Dawes [to 1905]” (PhD University of Chicago, 1952). Bascom N. Timmons, *Portrait of an American: Charles G. Dawes* (New York: Henry Holt and Co., 1953). Paul Roscoe Leach, *That Man Dawes* (Chicago: The Reilly and Lee Co., 1930).

<sup>66</sup> Dawes encouraged his committee to act like “officers of a big corporation” instead of members of congressional investigative committees, which he implied were inefficient. Proceedings of Committee Appointed by the President of the United States to Investigate the Administration of Law in Caring for the Crippled and Impaired Soldiers of the Late World War, (Washington, D.C., April 5, 1921). The proceedings are quoted as “Exhibit 2” in Hearings before a Subcommittee of the Committee on Interstate and Foreign Commerce of the House of Representatives, H.R. 3, Part I. The quote regarding corporations versus investigative committees is on p. 45.

<sup>67</sup> The quote is from R.E. Adkins, Medical Care of Veterans, Ninetieth Congress, First Session, (Washington, D.C. : United States Government Printing Office, April 1967), 104-08. Thomas A. Rumer also argues that Dawes “set the tone.” Thomas A. Rumer, *The American Legion: An Official History 1919-1989* (New York: M. Evans & Company, Inc., 1990), 134.

<sup>68</sup> In his account of the founding of the Veterans’ Bureau, Ronald Hamowy also notes that Dawes turned over authority to the American Legion. Ronald Hamowy, *Government and Public Health in America* (Northampton, MA: Edward Elgar Publishing, Inc., 2007), 271-340.

know why more than 10,000 available beds at army and navy hospitals could not be used for veteran patients in need. The answer, he contended, was that no one bureau existed which could demand that such beds be turned over. “Our house is on fire,” Sawyer said, arguing that patients needed to be put in any institution that had space.

Doctors familiar with the situation took issue with Sawyer’s rationale. Even if someone had “autocratic power,” one physician said, it would be difficult to find places for existing patients in available facilities. Hospitals, Thomas Salmon said, were not like “stables or garages.” They had limited numbers of beds for specific types of cases. Patients with mental illness and tuberculosis, he said – patients who may be threatening suicide, for example – could not be placed in just any medical ward. Not to mention the fact that, “a man can not be grabbed up and taken to a hospital,” said Army Surgeon General Ireland. Unless facilities were relatively advanced and close to ex-service members’ home, he said, they would likely resist seeking treatment. William White articulated a related point: “The only way to get beds for mental or tubercular cases,” he said, “is to build them at the government expense.” This met with the approval of American Legion representatives, who repeatedly argued that the \$18 million allotted by the Langley Bill was not nearly enough to accomplish all that was needed. Ex-soldiers, they said, could immediately be placed in available empty beds in the short-term, but in the very near future, many millions of dollars more would be necessary to undertake a “permanent building program.”<sup>69</sup>

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<sup>69</sup> Proceedings of Committee Appointed by the President of the United States to Investigate the Administration of Law in Caring for the Crippled and Impaired Soldiers of the Late World War. Cited in Hearings before a Subcommittee of the Committee on Interstate and Foreign Commerce of the House of Representatives, H.R. 3, Part I, 44-118. The Dawes Committee meeting marked one of the first exchanges between Sawyer and American Legion leaders, and the beginning of an increasingly contentious relationship. AL representatives often accused the President’s doctor, who, as we will see, later became an important presence in policy discussions, of emphasizing economy over ensuring that ex-service members received the very best care.



The Dawes committee broached a series of other difficult questions. How, for example, should a prospective veterans' bureau be organized? Would each state have a district office, or would the organization follow the structure of the FBVE and the PHS, which had 14 regional offices? There was also the issue of salary limits. BWRI, FBVE, and PHS representatives all reported that it was difficult to recruit qualified professionals given restrictions on how much they could pay them. How could this new organization get around that matter? Another pressing concern was what to do with the estimated twenty percent of veterans who remained in institutions even though they were well enough to be discharged. Uniform rules and regulations had to be adopted to ensure that patients were not spending an unnecessarily long time in institutions, but who would conceive of and enforce them?

Late on the first night of the committee meetings, the Legion's Galbraith posed one of the most crucial questions regarding the future of veterans' hospital care. If the government forged ahead with its plan to put in place a permanent hospital system, he asked, which government entity would operate the facilities – the new veterans' agency, the PHS, the military? William White's response revealed the fact that while the American Legion clearly aimed to demonstrate the need for institutions that would be used indefinitely and solely for veterans, civilian medical professionals intended to create a temporary fix, then arrange for facilities to be turned over for the general use of the public. The hospitals, White told Galbraith, would be run not by the proposed Bureau for Veterans' Affairs, but instead "by the departments for which they are built," such as the Public Health Service and the National Home for Disabled Volunteer Soldiers.<sup>70</sup>

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<sup>70</sup> Proceedings of Committee Appointed by the President of the United States to Investigate the Administration of Law in Caring for the Crippled and Impaired Soldiers of the Late World War. Cited in Hearings before a Subcommittee of the Committee on Interstate and Foreign Commerce of the House of Representatives, H.R. 3, Part I, 44-118.

Apart from these significant areas of disagreement and difficulty, the Dawes committee was able to reach a consensus regarding two important matters. First, no one outwardly disagreed with the idea that the government had to first deal with the emergency situation and get soldiers who needed care into hospitals immediately, and that it also had to organize and oversee a large-scale building program. After all, medical experts pointed out that the apex of the patient load would not be reached until at least the late 1920s. Another major point of agreement was that one government agency was needed to oversee the administration of rehabilitation, medical, social, and vocational services for veterans. What that agency would look like and who would head it was unclear, but committee members concurred that it should assume control over the BWRI and all activities of the FBVE and PHS having to do with ex-service members. The idea that the PHS, in its entirety, should be placed under the control of the new veterans' agency was proposed – as it had been during hearings over the Rogers Bill – this time, by Uel Lamkin of the FBVE. Surgeon General Cumming repeated his argument that, because the PHS performed many functions for the benefit of the civilian public, folding it into the new veterans' agency would amount to sacrificing the good of many for the good of the few. All present thus agreed that the PHS should serve as a contracting organization, which the new bureau could call on to administer hospital and other services. Committee members also agreed that whoever was chosen as the director of the new entity should be seen as having “one of the greatest honors that the president can bestow,” and have a tremendous amount of freedom and autonomy so he might fulfill his duties to the fullest.

Thanks in part to Dawes' ability to consistently bring his committee members back to what he called the “bird's eye view” and emphasize points of harmony, after three days of meetings, the group was able to compile seven recommendations to pass directly on to President

Harding. Among other things the list included the suggestions that a veterans' service administration be established encompassing the BWRI and sections of the FBVE and PHS; that "inconsistencies" in past legislation be eliminated and the director of the new agency be allowed to pay his employees what he deemed fit; that all government hospital facilities be made available for the use of the new agency; and that a "continuing hospital building program to provide satisfactory care for the disabled veterans of the world war be entered upon at once," overseen by the White committee.

The Dawes Committee provided a forum for advocates and government officials to discuss their perspectives and differences prior to the drafting of new legislation and congressional hearings. Bold, but short on detail, the committee's recommendations served as a foundation for what would become the Veterans' Bureau, and the building of a nationwide hospital system for ex-service members.

*Political victory: The establishment of the Veterans' Bureau, and the seeds of a national hospital system*

On May 7, 1921, Congressman Burton Sweet (R-IA), who had introduced some of the most prominent recent bills expanding ex-service members' benefits, laid out his plan for a Veterans' Bureau, which was based on recommendations from government officials involved in the system as well as suggestions from advocacy groups. Its 29 sections accomplished almost all of what the Dawes Committee had recommended, and then some. During congressional hearings in the summer of 1921, a few important issues concerning the proposed legislation were brought to the fore during congressional hearings.

One sticking point was the question of how lasting and extensive to make the infrastructure of the proposed Veterans' Bureau. Edwin Bettelheim, Jr., Chairman of the

Veterans of Foreign Wars Legislative Committee, argued for permanence by asking Congress to stipulate in the legislation that PHS hospitals be immediately turned over to the new bureau. He also pointed out a clause in the Bill stating that all regional offices of the VB would terminate by June 30, 1926, and asked that it be removed. “There is not a man in this country who can tell when those offices should terminate,” Bettelheim said. The director of the new bureau, Bettelheim said, should have the power to terminate the offices at his own discretion only after it was clear that they were no longer needed. Senators Reed Smoot (R – UT) and David I. Walsh (D – MA) both retorted that as the number of patients decreased during the next five years, the law should provide that the number of administrative offices would also decrease. Smoot argued that including a termination date was beside the point, since the legislation would likely be amended well before 1926.<sup>71</sup>

Furthering the argument that the longevity of the VB had to be limited, Smoot relayed his concern with a section of the bill stipulating that benefits would cover not only veterans whose injuries or illnesses could be conclusively proven to be “upon service origin,” but also ex-soldiers whose ailments had been “aggravated” in service. For example, according to the proposed legislation, if a soldier was admitted to the military with arrested tuberculosis, and the condition was noted in his record, he would be eligible for medical and disability benefits for that condition within two years of his discharge.<sup>72</sup> The precedent that benefits could be granted for injuries or illnesses aggravated in service had previously been set, most recently via June

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<sup>71</sup> Hearings before a Subcommittee of the Committee on Finance, United States Senate, on H.R. 6611, an Act to Establish in the Treasury Department a Veterans' Bureau and to Improve the Facilities and Service of Such Bureau, and Further to Amend and Modify the War Risk Insurance Act, Sixty-Seventh Congress, First Session, (Washington, D.C.: Government Printing Office, July 5 and 7, 1921), 17-20.

<sup>72</sup> At this point, all ex-soldiers, whether they had incurred tuberculosis in the line of duty or were reported to have it upon entrance into the service, had to prove the condition arose within two years of discharge. As the next chapter will discuss, the World War Veterans' Act of 1924 expanded eligibility for benefits and hospital care to any and all veterans, regardless of service connection or time elapsed since discharge.

1919 amendments to the Vocational Rehabilitation Act.<sup>73</sup> But when it came to hospital care, such a guarantee, Smoot said, would “work havoc.” Addressing the author of the legislation, Burton Sweet, Smoot contended that if an injury was of service origin, it should be “taken care of,” but:

This thing is wide open; there is no limit to it and from the way you have carried it on here in other places, I do not know whether we could get documents enough to follow them up, and if they did follow them up there is not one case out of a hundred that could ever be stated positively... every soldier thinks his case is an aggravated one. There will be no end to the examinations; there will be no end to the dissatisfaction; there will be no end to the demands for the next 50 years for increases under that provision. I can not see where we will ever get off.<sup>74</sup>

In spite of their concerns regarding some details of the bill, Smoot and Walsh joined a chorus of legislators who supported its passage. They, along with a great majority of their colleagues in both houses of Congress believed that the Veterans’ Bureau was the best available means of quelling an out-of-control situation: “Further continuation of the present system of separate bureaus handling the problems which are so closely interrelated,” a 1921 Senate report said, “would be not only unfavorable from the viewpoint of our incapacitated war veterans, but would be a pitiable reflection on Congressional inability to bring about quick beneficial changes in the present laws.”<sup>75</sup> In the lead-up to a Senate vote on the Bill on July 20, 1921, David I. Walsh urged an amendment to the Act that would absolve veterans and nurses with tuberculosis or “neuropsychiatric disease” from having to prove that their conditions were contracted in military service. He justified his proposal by citing the dissatisfaction of BWRI beneficiaries:

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<sup>73</sup> Economic Systems Inc., V.A. Disability Compensation Program: Legislative History, (Washington, D.C.: V.A. Office of Policy, Planning, and Preparedness, December 2004), 35.

<sup>74</sup> Hearings before a Subcommittee of the Committee on Finance, United States Senate, on H.R. 6611, an Act to Establish in the Treasury Department a Veterans' Bureau and to Improve the Facilities and Service of Such Bureau, and Further to Amend and Modify the War Risk Insurance Act, Sixty-Seventh Congress, First Session, (Washington, D.C.: Government Printing Office, July 11, 1921), 32.

<sup>75</sup> Investigation of Incapacitated Soldiers' Relief Bureaus, S. Rpt. 233, (Washington, D.C.: Government Printing Office, July 20, 1921). The report was published the same day the Senate voted on the VB Bill.

“The men who have been most disappointed, the wave of protest, I might say, against these bureaus and the Government have come from these men who have these diseases, know they have them, have had it demonstrated by doctors that they have them, and then have the Government say to them, ‘Prove it, prove it, prove that you have the disease as a result of your service.’” The rule resulted in veterans having to “go about looking for affidavits and looking for evidence,” leading to “much trouble and inconvenience.” Walsh looked for approval to Smoot, who responded that he had “no objection” to the amendment. Within minutes, (though more than two months after it was introduced in Congress), the bill was passed in the Senate.<sup>76</sup> Legislation to establish the Veterans’ Bureau also found strong support in the House. There, not one representative voted against it.<sup>77</sup>

Immediately following the House vote, Burton Sweet paid tribute to Col. Frederick W. Galbraith, the National Commander of the American Legion, who had “taken an active and enthusiastic part in the framing” of the VB legislation. Killed in a car crash just a few weeks before the House vote on the Bill, Galbraith was “well and favorably known by a large number of the Members of the House and Senate,” according to Sweet, and was constantly “discussing and setting forth the needs of his comrades.”<sup>78</sup> Sweet’s heartfelt tribute to Galbraith on the

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<sup>76</sup> No roll call vote was taken. United States Congressional Record, Senate, Sixty-Seventh Congress, First Session, (Washington, D.C.: Government Printing Office, July 20, 1921), 4106.

<sup>77</sup> Although 96 House representatives (who hailed from both parties and all regions) did miss the roll call vote – at least a few of them were “unavoidably absent” – no policymaker took a stand against the Bill. United States Congressional Record, House, Sixty-Seventh Congress, First Session, (Washington, D.C.: Government Printing Office, June 10, 1921), 2428. Two of the representatives who missed the vote on the VB were Royal C. Johnson (R—SD) and John W. Langley (R—KY), who appear in this dissertation as strong advocates for veterans. Their absence suggests that at least some of those who abstained from voting did not oppose the expansion of veterans’ benefits. The official vote tally was 335 Yeas; zero Noes. For context on interest group politics, as well as the extent of power of veterans’ groups, and their lack of political opposition, see Chapter Five of this dissertation.

<sup>78</sup> Ibid., 2428-9. Galbraith was highly revered and deeply mourned by many. “Our faith in our country is strengthened in that it can breed such men,” Theodore Roosevelt said in a eulogy offered at Galbraith’s funeral. “Good citizen, tender husband and father, valiant soldier, splendid idealist – his death has left us poorer but his life has left us richer.” “Thousands Mourn at Galbraith Bier,” *The New York Times* June 12, 1921.

congressional floor was a testament to the respect offered by legislators to the American Legion and its representatives.

Ultimately signed into law on August 9, 1921, “an Act to Establish a Veterans’ Bureau” granted extensive power to the organization’s director, and laid the groundwork for the most far-reaching system of federally sponsored hospital care in the U.S. The new bureau would replace the BWRI, and assume responsibility for all functions concerning veterans performed by the FBVE, and the PHS.<sup>79</sup> Each of the agencies would transfer records and personnel to the new VB. Although details regarding the bureau’s structure would be determined by its new director, the legislation stated that there would be one central office in Washington, DC, 14 regional offices, and up to 140 “suboffices” scattered throughout the country.<sup>80</sup> Concerns brought up by Bettelheim of the VFW regarding the inclusion of a termination date for the regional offices went unheeded; by legislating that the offices would close on or before June 30, 1926, members of Congress demonstrated their initial conviction that the VB should be a temporary bureaucracy.<sup>81</sup>

Other aspects of the legislation ensured that the new organization would be – as veterans groups had hoped – a lasting institution. In addition to overseeing the disbursement of insurance

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<sup>79</sup> Powers had been gradually transferred from the Army to the PHS, and from the PHS to the BWRI in the lead-up to the establishment of the Veterans’ Bureau. On April 19, 1921, the Secretary of the Treasury transferred to the Bureau of War Risk Insurance all veteran-related activities of the PHS except hospital and dispensary care. On July 1, 1921, all World War I veterans were discharged from the Army and taken under auspices of Public Health service.

<sup>80</sup> An Act to Establish a Veterans' Bureau and to Improve the Facilities and Services of Such Bureau, and Further to Amend and Modify the War Risk Insurance Act, Public Law 47, H.R. 6611, 42 Stat., 147, Sixty-Seventh Congress, First Session, (Washington, D.C.: Government Printing Office, August 9, 1921). Kathleen Frydl argues that such a decentralized organizational structure helped the agency gain popular appeal and continue on a growth trajectory in the post-World War II years. Kathleen J. Frydl, *The G.I. Bill* (New York, New York: Cambridge University Press, 2009), See especially p. 128-29.

<sup>81</sup> An Act to Establish a Veterans' Bureau and to Improve the Facilities and Services of Such Bureau, and Further to Amend and Modify the War Risk Insurance Act, Public Law 47, H.R. 6611, 42 Stat., 147.

benefits and vocational education, the bureau would be responsible for providing examinations, medical care, treatment, hospitalization, dispensary, and convalescent care not only for veterans who had incurred injuries or illnesses in the line of duty, but also for those whose pre-existing conditions had been aggravated in service. This latter clause, as Senator Smoot predicted when he questioned it during Congressional hearings, helped pave the way for the 1924 extension of federal benefits to *all* veterans; by that point, government officials were simply overwhelmed with handling lengthy claims attempting to prove service origin or aggravation. The law also included David I. Walsh's proposed amendment regarding presumed service connection for tuberculosis and neuropsychiatric diseases, a major boon for veterans' advocates, which aimed to ensure that VB hospitals would be fully accessible to veterans suffering from the most common chronic conditions resulting from the late war.

Two other measures included in the VB legislation, regarding institutional expansion and control, helped ensure the agency would grow instead of shrink over time. The law provided that PHS hospitals housing veterans could be transferred to the VB at the President's discretion. It also said that if proper facilities were not available to provide care for veterans through the PHS, Army, Navy, and Old Soldiers' Homes, the director of the VB could "acquire additional facilities." The latter could then be placed under the direct control of the VB, as opposed to being handed over to other agencies, as William White suggested should be done during meetings of the Dawes Committee. The head of the new bureau was thus given license to grow a veterans' hospital system as he deemed fit. It followed that efforts undertaken by the White Committee prior to the establishment of the VB to ensure that government funding would be spent on improving and *temporarily* expanding available medical facilities and services for veterans, soon gave way to a *permanent* building program propelled and overseen by the VB.



## Conclusion

Scholars note that the limited population initially covered by VB medical benefits gradually expanded throughout the 1920s, and argue that the law in its original form “was not quite as generous as it seemed.”<sup>82</sup> Still, the legislation marked a turning point in the history of the veterans’ welfare state: it established a service-oriented agency solely for the benefit of former service members. It included almost every major request of veterans’ groups. And most importantly, it served as a seed for future growth for what one scholar calls “the single most powerful social policy agency in U.S. history.”<sup>83</sup>

An examination of World War I era policy debates concerning the medical care of ex-soldiers reveals that a veterans’ hospital system was never truly deliberately legislated. Once the Veterans’ Bureau was created and vested with the authority to build institutions and administer medical services, however, the roots of such a system were planted. The subsequent, aggressively pro-active lobbying of veterans’ groups, coupled with eager building drives undertaken by overlapping federal agencies, resulted in generous allotments for construction of new facilities and a more far-reaching national system of veterans’ hospitals than many in the government originally thought necessary or advisable.

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<sup>82</sup> The quote is from Sanders Marble, *Rehabilitating the Wounded: Historical Perspectives on Army Policy*, (Falls Church, VA, July 2008), 27. K. Walter Hickel provides a helpful description of the nature and extent of the expansion of veterans’ benefits throughout the 1920s. Hickel, “Entitling Citizens: World War I, Progressivism, and the American Welfare State, 1917–1928”, 128-46.

<sup>83</sup> Frydl, *The G.I. Bill*, 49.

## CHAPTER SEVEN

### **“That centralization of activities that some people call socialism”: Empowering the Veterans’ Bureau and growing a veterans’ hospital system (1921-1924)<sup>1</sup>**

The Veterans’ Bureau was initially granted limited powers pertaining to the administration of medical services, but it had a tremendous capacity for growth. Between August 1921 and June 1922, the agency went from overseeing the care of its beneficiaries in a variety of government and private institutions, to managing 47 of its own hospitals. It also won funding to undertake its very own hospital building program. Charles R. Forbes, the first director of the Veterans’ Bureau, is most commonly remembered as a corrupt figure who bilked the government and the country’s former service members out of millions of dollars. But his aggressive drive to expand the powers of his new agency helped ensure that the Veterans’ Bureau would gain control of all hospitals treating veterans, and that the system would be both highly autonomous, and in place for many years to come. In fact, by 1924, advocates argued that veterans’ hospitals should be open to all who served (and not just those whose injuries could be connected to service) in part, because there was a surplus of hospital beds. Their requests were answered with the passage of the World War Veterans’ Act in 1924, which helped ensure that demand for newly planned facilities would continue, and likely increase, for years.

The 1924 World War Veterans’ Act was important for another reason; it granted ex-soldiers a distinct welfare privilege as a reward for their membership in a powerful interest group of citizen-veterans, not by virtue of having incurred an injury or illness in the line of duty.

Although the precedent for universal veterans’ benefits and a “citizen-veteran” class had been set

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<sup>1</sup> The quote is from Hearings before the Committee on World War Veterans' Legislation, House of Representatives, on Proposed Legislation as Recommended by the Director of the United States Veterans' Bureau and American Legion, Disabled American Veterans, and Veterans of Foreign Wars, Sixty-Eighth Congress, First Session, (Washington, D.C.: Government Printing Office, February 20, 1924), 47.

by liberal pension laws in the post-Civil War years, the establishment of the privilege of access to hospital care had enduring consequences: it gave veterans a highly visible and increasingly valuable institutionally-oriented connection with their government, and it paved the way for the veterans' medical system that remains intact to this day.

### *The Veterans' Bureau gains autonomy*

In the short-term, the creation of the Veterans' Bureau led to more, not less, bureaucratic confusion. The task of transferring paperwork, office space, facilities, and personnel from the BWRI to the VB proved onerous.<sup>2</sup> Furthermore, VB staff, officials from federal agencies already involved in veterans' care, and members of the White Committee, which had been placed in charge of deciphering a hospital improvement and expansion program approximately five months prior to the founding of the Veterans' Bureau, had questions regarding how they would divide and share responsibilities. For example, would the PHS and White Committee serve the VB, or be overtaken by it? Finally, there was the crucial issue of leadership, and who would take the helm of the new bureau.

In March 1921, Warren G. Harding had barely served a day in office when R.G. Cholmeley-Jones stepped down from his post as Director of the Bureau of War Risk Insurance to return to work at a financial services firm in New York City. In spite of allegations of bureaucratic dysfunction throughout 1919 and 1920, bureaucrats and veterans' advocates alike credited Cholmeley-Jones with performing well at an almost impossibly tough job, and making the BWRI more efficient.<sup>3</sup>

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<sup>2</sup> A useful summary of this transition period can be found in Annual Report of the Director, United States Veterans' Bureau for the Fiscal Year Ended June 30, 1922, (Washington, D.C.: Government Printing Office, 1922), 1-24.

<sup>3</sup> On Cholmeley-Jones' resignation, see "Cholmeley-Jones Resigns; Quits War Risk Bureau to Enter Corporation in New York.," *The New York Times* March 6, 1921. On April 9, Treasury Secretary Andrew Mellon reappointed

Harding chose as his replacement Charles R. Forbes, who, after emigrating from Scotland as a child, attended the Massachusetts Institute of Technology and made his living as an engineer in the construction industry. Forbes served in the army during the Spanish-American War and soon thereafter, as a sergeant in the Signal Corps. Prior to World War I, he was working on various federal committees in Hawaii, where he met and became fast friends with a traveling Warren G. Harding.<sup>4</sup> Forbes' apparent lack of specifically relevant experience for the task at hand was highlighted by a *New York Tribune* report noting that, up until the day before his appointment, the president was debating between making him the Governor of Alaska, or the head of the BWRI.<sup>5</sup> According to Rosemary A. Stevens, "The new bureau needed someone of impeccable status, a rock-hard reputation, first-rate professional credentials, and superb people-skills. Forbes had none of these attributes."<sup>6</sup>

Veterans' groups registered their early reservations with Forbes' appointment. Edwin S. Bettelheim, Jr., of the Veterans of Foreign Wars testified at a Senate hearing that "Colonel Forbes is a very good man," but that the "present incumbent" should not necessarily automatically be appointed the head of the new Veterans' Bureau.<sup>7</sup> In spite of the reservations of the VFW and others, Forbes got the job.

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Cholmeley-Jones. "Cholmeley-Jones to Stay," *The New York Times* April 10, 1921. A few weeks later, as Cholmeley-Jones noted that he had only accepted the reappointment "to render emergency services," he was replaced by Charles Forbes. "Takes War Insurance Job; Colonel C.R. Forbes Named to Succeed R.G. Cholmeley-Jones," *The New York Times* April 28, 1921. For details about the BWRI under Cholmeley-Jones, see Chapter Four.

<sup>4</sup> "Col. C. Forbes Dies; Led Veterans' Unit," *The New York Times* April 12, 1952.

<sup>5</sup> "F.M. Goodwin Named for Assistant Interior Post," *New York Tribune* April 26, 1921.

<sup>6</sup> Rosemary A. Stevens, "The Invention, Stumbling, and Re-Invention of the Modern U.S. Veterans Health Care System, 1918-1924," in *Veterans' Policies, Veterans' Politics: New Perspectives on Veterans in the Modern United States*, ed. Stephen R. Ortiz (Gainesville: University Press of Florida, 2012).

<sup>7</sup> Hearings before a Subcommittee of the Committee on Finance, United States Senate, on H.R. 6611, an Act to Establish in the Treasury Department a Veterans' Bureau and to Improve the Facilities and Service of Such Bureau,

Those who shaped the legislation establishing the VB aimed to ensure centralized control over hospitalization, but Forbes' new bureau entered a crowded, somewhat chaotic field of medical services. The bulk of veteran patients were located in Public Health Service Hospitals, though many were scattered in other federal, state and private contract institutions. Meanwhile, the White Committee forged ahead with plans to systematically improve medical facilities serving veterans across the country. By the August 1921 founding of the VB, the White Committee had released a comprehensive plan regarding hospital needs, and received approval to build, expand, or improve 13 facilities across the country.<sup>8</sup>

From the first, Forbes demonstrated great eagerness to control all aspects of the hospital building program. He set out to usurp control from the White Committee – and by extension, the Department of the Treasury – and win more government funding for his agency. As early as the fall of 1921, Forbes began making the case that the White Committee had been inefficient and lackadaisical, and that the VB should have full autonomy when it came to improving and constructing hospitals.

The new director first took his claim to the newly formed Federal Board of Hospitalization (FBH). Established by the Harding administration in November 1921 – three months after the Veterans' Bureau – the Board was intended to “consider all questions relative to the coordination of hospitalization” of all federal entities overseeing hospitals: the new VB, the Army, Navy, Public Health Service, National Home for Disabled Volunteer Soldiers, Department of Indian Affairs, and the so-called Government Hospital for the Insane, St.

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and Further to Amend and Modify the War Risk Insurance Act, Sixty-Seventh Congress, First Session, (Washington, D.C.: Government Printing Office, July 5 and 7, 1921), 15.

<sup>8</sup> Report of the Consultants on Hospitalization Appointed by the Secretary of the Treasury to Provide Additional Hospital Facilities under Public Act 384, (Washington, D.C.: Government Printing Office, 1923), 41-55. In the months following, the Committee would put forth plans for six more institutions.

Elizabeth's in Washington, D.C. Growing in part out of a larger contemporary movement to ensure that hospitals across the U.S. meet the same universal criteria, the Board aimed to "standardize requirements" so that facilities, supplies, and buildings could be shared between government departments. It also aimed to "formulate plans designed to knit together in proper coordination the activities of the several departments" in the interest of the government and improving efficiency.<sup>9</sup> During early meetings of the Federal Board, the issue of veterans' medical care commanded much attention.

Soon after the November founding of the FBH, Forbes drafted a letter asking its members to support the so-called "second Langley Bill," which would allocate \$17 million to the VB to oversee eight new hospital projects. The institutions, Forbes said, would be pursued separate and apart from the projects already under the auspices of the White Committee, which had control over the \$18.6 million allocated earlier in 1921 under the "first Langley Bill."<sup>10</sup> "It is felt that the recommendation of your board... in the matter of hospitalization will be a source of strength to this Bureau in making its wants known to congress," Forbes wrote to the FBH.<sup>11</sup> During Senate hearings on the second Langley Bill in December 1921, Forbes not only argued that the \$17 million appropriation was necessary, but also touted the judgment from the Federal Board of Hospitalization that "the money provided" should be "disbursed under the direction of the Director of the United States Veterans' Bureau." In case there was any doubt of the implications,

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<sup>9</sup> "Annual Report, Federal Board of Hospitalization, 1924", June 1924, 1. Records of the Federal Board of Hospitalization, General Records, 1921-1948 Record Group 51, Box 15, Entry 3, National Archives and Records Administration, College Park, Maryland. Also see: "Draft of Circular No. 44: Federal Board of Hospitalization", November 1, 1921. Records of the Federal Board of Hospitalization, General Records, 1921-1948 Record Group 51, Box 1, Entry 3, National Archives and Records Administration, College Park, Maryland.

<sup>10</sup> See Chapter Six for a discussion of the first Langley Bill.

<sup>11</sup> "Letter from Charles Forbes", November 29, 1921. Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans' Bureau, 1917-1923, Record Group 90, Box 7, NC-34, Entry 23, National Archives and Records Administration, College Park, Maryland.

Robert U. Patterson, assistant director of the Veterans' Bureau Medical Division, noted: "The board expressed the opinion that (the money) should be disbursed as the director (of the VB) sees best, in his judgment, and not by the Secretary of the Treasury."<sup>12</sup>

When senators present wondered about the status of the previously allocated \$18.6 million controlled by the White Committee, Forbes dismissed the group's efforts: "None of the hospitals that were to be constructed... are completed," he said. "There are some of them that are not started." The Treasury Department, Forbes noted, was slow to take action, and wasteful in the way it assigned contracts.<sup>13</sup> In later hearings, Forbes detailed the "crying demand" for more hospitals in populous districts like New York, improved facilities in the South, and more dispensaries across the country. Expansions and additions provided for under the White Committee, he said, were insufficient.<sup>14</sup>

Thanks in part to Forbes' lobbying, the spring of 1922 saw a great expansion in VB powers. An April 29, 1922 Executive Order referred to previous legislation that had established the VB, which stated that the director of the bureau could request additional facilities if they were deemed necessary, and went even further. Although the White Committee would continue

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<sup>12</sup> Hearings before the Subcommittee of the Committee on Appropriations, United States Senate, on H.R. 9237, a Bill Making Appropriations to Supply Deficiencies in Appropriations for the Fiscal Year Ending June 30, 1922... Sixty-Seventh Congress, Second Session, (Washington, D.C.: Government Printing Office, December 6, 1921). The January 10, 1922 meeting minutes of the Federal Board of Hospitalization contain the FBH's approval of Forbes' request to oversee hospital building. The Board unanimously decided that the Veterans' Bureau would determine "the locations and kind of hospitals to be built and operated for the care of world war veterans." "Proceedings of the Federal Board of Hospitalization (Addendum to Minutes of Eleventh Meeting of the Federal Board of Hospitalization)", January 10, 1922. Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans Bureau, 1917-1923, Record Group 90, Box 6, NC-34 Entry 23, National Archives and Records Administration, College Park, Maryland.

<sup>13</sup> Hearings before the Subcommittee of the Committee on Appropriations, United States Senate, on H.R. 9237, a Bill Making Appropriations to Supply Deficiencies in Appropriations for the Fiscal Year Ending June 30, 1922... 8.

<sup>14</sup> Hearings before the Committee on Public Buildings and Grounds, House of Representatives, on H.R. 8791, Additional Hospital Facilities, Sixty-Seventh Congress, Second Session, (Washington, D.C.: Government Printing Office, February 8, 1922), The quote is from p. 4.

to exist and pursue projects approved under the first Langley Bill, the order stipulated that the VB would gain control of the facilities once they were completed. It also gave the VB control over 57 Public Health Service facilities primarily serving former soldiers, sailors, and marines.<sup>15</sup> In essence, the executive order marked the Treasury Department's departure from direct involvement in the administration of veterans' hospital care. Here was a step towards full autonomy for the Veterans' Bureau in the arena of the provision of medical care. The goal of ensuring that all former service members would be treated in *government* hospitals, was gradually giving way to the ideal that they would be treated in *veterans'* hospitals – facilities intended solely for them. Forbes' agency gained further power and autonomy with the May 1922 approval of the second Langley Bill, or Public Law 216, which granted \$17 million directly to the VB, so that the agency could “provide for the construction of additional hospital facilities and... medical, surgical, and hospital services and supplies” for veterans.<sup>16</sup>

Another, related act – a response to claims that there was “clear discrimination against” those who served in previous conflicts who were “not getting an equal show with the veterans of the late war” – greatly expanded the VB's pool of potential claimants. It stipulated that the bureau would sponsor medical care for a variety of groups of veterans, not just ex-soldiers of the World War. Congressional representatives claimed that a law passed in March 1919, which opened Public Health Service facilities to all “discharged sick and disabled soldiers, sailors, and marines,” meant that all veterans were already guaranteed access to government hospitals. But, in spite of previous legislation, representatives of Spanish-American War veterans claimed they

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<sup>15</sup> Executive Order 3669, (Washington, D.C.: Government Printing Office, April 29, 1922).

<sup>16</sup> An Act Making an Appropriation for Additional Hospital Facilities for Patients of the United States Veterans' Bureau, Public Law 216, H.R. 11547, 42 Stat. 507, Sixty-Seventh Congress, Second Session, (Washington, D.C.: Government Printing Office, May 11, 1922).



were being denied treatment. By naming in legislation the groups of veterans to whom hospitals were to be available, advocates argued, the confusion could be avoided. As William L. Mattocks, editor of the United Spanish-American War Veterans National Tribune put it, “We, of course, feel that the veterans of the Spanish War are entitled to the same medical attention” as those of the World War. Thanks to their efforts, Public Law 194 ensured that hospitals and other medical provisions of the VB would be available to “persons who served in the World War, the Spanish-American War, the Philippine Insurrection, and the Boxer Rebellion.”<sup>17</sup> Gradually, the government was expanding benefits, and growing the purview of the Veterans’ Bureau.

By June 1922, less than a year after its establishment, the VB oversaw care for more than 18,000 patients in 96 government hospitals; the bureau owned and operated 47 of the institutions. Those 47 “veterans’ hospitals” provided treatment for almost 12,000 patients. While the capacity of the VB continued to grow, the agency faced a challenge in fulfilling the mandate to locate all hospitalized veterans in VB facilities – as opposed to other government owned or government contracted hospitals – not least of all because many former soldiers resisted being moved to institutions that were far from their homes.<sup>18</sup> While more than 5,400 Bureau beds remained vacant, no fewer than 6,000 veteran-patients were being treated in Public Health Service, army, and navy hospitals, Soldiers’ Homes, and St. Elizabeth’s, the Washington, D.C.-based federal

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<sup>17</sup> An Act to Authorize an Appropriation to Enable the Director of the United States Veterans' Bureau to Provide for the Construction of Additional Hospital Facilities and to Provide Medical, Surgical, and Hospital Services and Supplies for Persons Who Served in the World War, the Spanish-American War, the Philippine Insurrection, and the Boxer Rebellion, and Are Patients of the United States Veterans' Bureau, Public Law 194, H.R. 10864, 42 Stat. 496, Sixty-Seventh Congress, Second Session, (Washington, D.C.: Government Printing Office, April 20, 1922).

<sup>18</sup> Chief Coordinator Brigadier General C.E. Sawyer, "Annual Report, Federal Board of Hospitalization, 1922" September 5, 1922. Records of the Federal Board of Hospitalization, General Records, 1921-1948 Record Group 51, Box 15, Entry 3, National Archives and Records Administration, College Park, MD. According to the 1922 annual report of the Veterans’ Bureau: “consistent effort was made to remove patients from contract hospitals to Veterans’ Bureau hospitals where vacant beds were available. Because of objection on the part of the patients to being transferred away from their home localities, this program has been considerably handicapped.” Annual Report of the Director, United States Veterans' Bureau for the Fiscal Year Ended June 30, 1922, 16-17.

hospital for neuropsychiatric patients.<sup>19</sup> An additional 2,248 patients underwent treatment in 1922 in more than 1,200 civil hospitals under contract with the Veterans' Bureau.<sup>20</sup> In addition to working with existing facilities, the VB pursued its own hospital projects, adding 3,650 beds to 13 institutions in 1922, all but one of them intended to serve neuropsychiatric and tuberculosis patients.<sup>21</sup> Separate and apart from the new beds being added by the VB, eleven veterans' hospitals were being constructed or expanded as per the advice of the White Committee; once completed, they would also be under the bureau's control.<sup>22</sup>

*The tale of Charles Sawyer, and the unassailability of the Legion agenda*

The story of Charles Sawyer, and his efforts to curtail spending on veterans' welfare helps explain why requests for funding for veterans' hospitals were so often granted. Sawyer played various roles in the Harding administration, always faithfully trumpeting the goals of economy and efficiency the president had emphasized on the campaign trail. His passion for those ideals – which were encapsulated, in part by his willingness to repeatedly argue that veterans might be treated in spare beds in soldiers' homes, as opposed to those designated specifically for them in more modern institutions – led the American Legion to undertake a lengthy and vigilant smear campaign against him.<sup>23</sup> Sawyer's experience showcases the

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<sup>19</sup> Annual Report of the Director, United States Veterans' Bureau for the Fiscal Year Ended June 30, 1922, 86-88.

<sup>20</sup> Although 1,255 hospitals were under contract with the VB in June 1922, the Bureau only used 648 of them. An additional 113 civil hospitals *not* under contract were also housing VB patients. *Ibid.*, 78-9.

<sup>21</sup> The largest of these institutions were to be at Tupper Lake, New York and Camp Custer, Michigan. Brigadier General C.E. Sawyer, "Annual Report, Federal Board of Hospitalization, 1922".

<sup>22</sup> The largest of these institutions were to be at Palo Alto, California, the Bronx, New York, and Milwaukee, Wisconsin. *Ibid.*

<sup>23</sup> For other accounts of the conflict, see Thomas A. Rumer, *The American Legion: An Official History 1919-1989* (New York: M. Evans & Company, Inc., 1990), 147-49. William Pencak, *For God and Country: The American*

challenges faced by those who chose to speak out against generous benefits for wounded and ill former soldiers.

Charles Sawyer played three major roles in the Harding administration. First, he was the president's personal physician. A homeopath who ran multiple lucrative sanatoria in Ohio, Sawyer earned the Harding family's trust by defending the future president's mother and fellow homeopath, Phoebe Harding, against claims that her prescribed treatment played a part in the death of a young boy in the summer of 1897. Soon after the episode, Sawyer began managing the treatment of Florence Harding's floating kidney condition; she came to believe that "Doc" (as the Hardings called Sawyer) "was the one man who could keep her alive." By the time Harding ran for President in 1920, Sawyer had become a close personal friend, and he served as an invaluable local booster during the campaign.<sup>24</sup>

Many viewed the political and professional credentials of Sawyer, who was a homeopath in an age when homeopathy was seen as an increasingly antiquated practice, with some skepticism. According to Joel T. Boone, a navy doctor who worked alongside Sawyer in caring for the Hardings during the administration, the president's family doctor was commissioned as a Brigadier General in the Reserves mainly because "President Harding realized that unless he paid him himself, Doctor Sawyer would have to have some military status... this action brought

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*Legion 1919-1941* (Boston: Northeastern University Press, 1989), 179-81. Carl Sferraza Anthony, *Florence Harding: The First Lady, the Jazz Age, and the Death of America's Most Scandalous President* (New York: William Morrow and Company, Inc. , 1998), 367-71.

<sup>24</sup> The quote is from Anthony, *Florence Harding: The First Lady, the Jazz Age, and the Death of America's Most Scandalous President*, 86; Phillip G. Payne, *Dead Last: The Public Memory of Warren G. Harding's Scandalous Legacy* (Athens, Ohio: Ohio University Press, 2009), 35. For a good description of Sawyer's education and background, including the description of how he came to know the Hardings, see Anthony, *Florence Harding: The First Lady, the Jazz Age, and the Death of America's Most Scandalous President*, 63.

forth much public criticism.”<sup>25</sup> One historian reports that Sawyer was known as ““the suddenest brigadier general in history.””<sup>26</sup> Members of Congress felt they could not very well justify opposing the nomination of Sawyer, given that they had approved a similar request by President Wilson, who successfully lobbied for his physician, Cary Grayson, to be appointed as a Rear Admiral in the Medical Corps of the Navy.<sup>27</sup> Although an earlier precedent had been set for Sawyer to obtain rank, the physician’s willingness to wear a uniform in spite of his lack of military experience gave “offense to real soldiers and sailors,” including some of the veterans’ activists who came to strenuously disagree with his policies.<sup>28</sup>

Beyond his position as family doctor, Sawyer also spearheaded an effort in the spring of 1921 to create a Department of Public Welfare, which Harding hoped would oversee ““affairs relating to public welfare,”” including public health and ““social justice,”” which he felt were ““vital to the nation’s perpetuity.””<sup>29</sup> Inspired by the notion that two-thirds of those eligible for the draft during the recent war were rejected because of “lack of physical capacity” and “mental inability,” as Sawyer put it, the proposed department would allow the United States government

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<sup>25</sup> Admiral Joel T. Boone, "Oral History Interview with Admiral Joel T. Boone by Raymond Henle, Director" July 22, 1967, 17. Scripps Library, Miller Center, University of Virginia, Charlottesville, Virginia.

<sup>26</sup> Eugene P. Trani; David L. Wilson, *The Presidency of Warren G. Harding* (Lawrence, Kansas: The Regents Press of Kansas, 1977), 45.

<sup>27</sup> When Sawyer was nominated, he was 62 years old – two years past the maximum age for commissioned, active duty personnel. But Harding’s Attorney General Harry M. Daugherty argued that the age limitations did not apply in times of war, and the U.S. was technically still at war with Germany in March 1921. "Sawyer Nomination Goes to the Senate," *The New York Times* March 9, 1921.

<sup>28</sup> "The Drive on Doctor Sawyer," *Peoria Transcript* October 22, 1922. Article accessed in Microfilms, Rehabilitation – Veterans' Administration Hospitals – Hospitalization (con't) Rehab – VA – Hospitals – Survey 1929 Library 92-1012, American Legion Library, Indianapolis, Indiana. According to a Florence Harding biographer, “Sawyer was an odd character,” whose “little pointed white beard, steamy white glasses, and hollow chest” made him look like “a cartoon dictator out of the Sunday funnies.” Anthony also notes that Sawyer used his new White House post to promote his sanitarium business. Anthony, *Florence Harding: The First Lady, the Jazz Age, and the Death of America's Most Scandalous President*, 248.

<sup>29</sup> White House statement, quoted in "Sawyer Nomination Goes to the Senate."

to proactively aid in the production of “the biggest, best and strongest citizen.” The department, which would contain four branches – education, public health, social service, and veterans’ services – also represented an effort by the Harding administration to respond in one fell swoop to various factions that had been lobbying for federal funding and power. “If cabinet officers were allowed to each one who is asking for it,” Sawyer contended, “it would result in a very unwieldy body as a cabinet of the United States.” Specifically, education advocates were fighting for their own department, as well as a law that would provide social and health services for impoverished women and children, and veterans’ advocates were fighting hard for the Veterans’ Bureau. The Public Health Service cost nearly \$50 million annually, and the “social service” problems of vocational accidents and “children’s well-being” were costing the government more time and money each year. In all, Sawyer estimated, the PHS, Bureau of War Risk Insurance, Children’s Bureau, Soldiers’ Homes, Employees Commission, Pension Bureau, Federal Board of Vocational Rehabilitation, Bureau of Education, and other related departments were allotted more than \$701 million annually. The proposed Department of Public Welfare, he suggested, would “bring them all into one united family” with the dual goals of “economy” and “efficiency.”<sup>30</sup>

Sawyer’s tendency towards thrift was evident in his proposals for the branch concerning veterans’ services. Apparently shrugging off previous controversies that had erupted following the transfer Great War veterans to soldiers’ homes, and prior discussions regarding the necessity of specialized beds for tuberculosis and mentally ill patients, he consistently argued that the latter

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<sup>30</sup> Department of Public Welfare, Joint Hearings before the Committees on Education, on S. 1607 and H.R. 5837, Sixty-Seventh Congress, First Session, (Washington, D.C.: Government Printing Office, May 11, 12, 13, 18, and 20, 1921), 4-18. For a description of the proposed department, see “Report of Brigadier Gen. C.E. Sawyer to the President Relative to the Creation of a Department of Public Welfare”, May 4, 1922. Records of the Federal Board of Hospitalization, General Records, 1921-1948 Record Group 51, Box 1, Entry 3, National Archives and Records Administration, College Park, Maryland.

institutions should be used to house injured and ill veterans of the recent war.<sup>31</sup> He understood that veterans' advocates wanted ex-service members treated close to their homes in up-to-date facilities. But, he noted, the Soldiers' Homes scattered throughout the nation were "wonderful properties." Their population was "decreasing very rapidly," and the government had "no other apparent use for them." Since most of the homes boasted extensive grounds, buildings could be erected, expanded, and improved according to need. World War veterans – who the Legion and other activists argued were too young to be confined to institutions with aged Civil War veterans – could bring the latter "joy and satisfaction," according to Sawyer. At the same time, he argued, Great War veterans could "take lessons" from their elder counterparts. "It will redound to the good of both," Sawyer maintained.<sup>32</sup>

During hearings for the Department of Public Welfare, the doctor exhibited the same lack of recognition of the complexity of the hospitalization situation as he had during the April 1921 Dawes Committee meetings focusing on shortfalls veterans' care. At the latter gathering, Sawyer had brought up the idea of treating World War I veterans in soldiers' home beds, and medical professionals involved in the system retorted that hospitals beds were not like "stables and garages," but were suitable for the treatment of specific maladies. The tuberculosis and mental illness suffered by veterans of the recent war, they suggested, would, in the main, be best treated in specialized medical facilities rather than soldiers' homes.<sup>33</sup> Sawyer also defiantly refused to

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<sup>31</sup> In the summer of 1920, Massachusetts veterans protested against being re-located from private contract hospitals to a Soldiers' Home at Togus, Maine. Their cause was taken up by the American Legion, which was eventually granted the right to review patient records before they were transferred. See Chapter Four for a description of the controversy.

<sup>32</sup> Department of Public Welfare, Joint Hearings before the Committees on Education, on S. 1607 and H.R. 5837, 10.

<sup>33</sup> See Chapter Six for a full discussion of the Dawes Committee meetings. Proceedings of Committee Appointed by the President of the United States to Investigate the Administration of Law in Caring for the Crippled and Impaired Soldiers of the Late World War, (Washington, D.C., April 5, 1921). The proceedings are quoted as "Exhibit 2" in

pay heed to two primary claims of veterans' groups: first, that the act of placing young Great War veterans in what were widely viewed as well-worn convalescent homes equated to a tacit rejection of the idea that they were capable of recovery, and second, that their rights should be viewed as separate, apart, and in some ways, above those of all others.<sup>34</sup>

Not surprisingly, many legislators and advocates felt their agendas were threatened by Sawyer's attempt to include their causes in his Department of Public Welfare "united family." Horace Mann Towner (R-IA), a tireless advocate for federal allotments for local education, and a primary sponsor of the Sheppard-Towner Act, which allotted federal entitlements to poor women and children, told Sawyer in no uncertain terms that he was "worried that education would be subordinated" in the department. The interests of "the public health men," who already enjoyed exponentially more funding, Towner feared, would "be dominant."<sup>35</sup>

The Department of Public Welfare never became a reality, however the Sheppard-Towner Act and the Veterans' Bureau legislation were passed in the fall of 1921, just months after Sawyer proposed his idea. Although the two laws served quite different populations, they were based on similar ideals surrounding gender and capitalism, and both were landmarks in the history of federal entitlements to citizens.<sup>36</sup> In spite of the fact that his bill was ultimately

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Hearings before a Subcommittee of the Committee on Interstate and Foreign Commerce of the House of Representatives, H.R. 3, Part I, Sixty-Seventh Congress, First Session, (Washington, D.C.: Government Printing Office, April 29, 1921), 44-118.

<sup>34</sup> This sentiment was conveyed in previous legislative hearings, as well as in the Dawes Committee meetings. American Legion historian, Thomas Rumer, also alludes to this principle: Rumer, *The American Legion: An Official History 1919-1989*, 147.

<sup>35</sup> Department of Public Welfare, Joint Hearings before the Committees on Education, on S. 1607 and H.R. 5837, 17. Towner's sentiment was representative of the feelings of many education advocates: Hugh S. Magill, "Education and the Federal Government," *Today's Education* 10-11 (November, 1921).

<sup>36</sup> Also justified in part by the high rate of recruits deemed ineligible for military service, the Sheppard-Towner Act provided resources for the education of pregnant women, and clinics focused on maternal health, mainly in rural areas. On Sheppard-Towner, see Nancy F. Cott, *The Grounding of Modern Feminism* (New Haven: Yale University Press, 1987), 98.

unsuccessful, hearings regarding the Department of Welfare helped Sawyer gain a reputation as cost-conscious, above all else, and to a fault – a trait many veterans’ advocates came to find abhorrent.

Once the Department of Public Welfare was scrapped, Sawyer assumed his third major role in the Harding administration, as the head of the Federal Board of Hospitalization, the entity established in November 1921 to coordinate hospital care administered by various federal entities, including the Veterans’ Bureau, the Army, Navy, Public Health Service, National Home for Disabled Soldiers, and the Department of Indian Affairs. In his role as the FBH Chief Coordinator, Sawyer continued to advocate for a more economical approach to hospitalization for ex-service members, much to the chagrin of American Legion officials. His position was finally publicly maligned in the summer of 1922, when he corresponded with Albert A. Sprague, Chairman of the National Rehabilitation Committee of the American Legion.<sup>37</sup>

In February 1922, Sprague made known his disapproval of Sawyer’s statements in a letter to Charles Dawes, who directed meetings in 1921 intended to decipher how veterans’ medical care might be improved, and was currently serving as Director of the new Bureau of the Budget.<sup>38</sup> The Legion leader told Dawes that he felt Sawyer’s “ill considered use of figures and statements that are not capable of proof in regard to adequate facilities and proper care of disabled ex-service men, will do incalculable harm.” They would, he argued, “shake the

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<sup>37</sup> William Pencak describes the interchange as one indication that the Legion was increasingly frustrated with the failure of the government to make good on its promises. See Pencak, *For God and Country: The American Legion 1919-1941*, 179-81. Sprague was a Chicago grocer by trade. In the Republican primary race of 1920, he supported Leonard Wood in his efforts against Harding and other candidates. By 1924, Sprague was so disenchanted with the Republican Party and the incumbent president, that he ran (unsuccessfully) as a Democratic Senator. "Col. Sprague, 69, Politician and Grocer, Is Dead ", *Chicago Tribune* April 8, 1946.

<sup>38</sup> For more on Dawes, and the committee he led regarding the creation of a veterans’ organization, see Chapter Six.



confidence in the administration and the integrity of its assertions that it is going and intends to do everything in its power to give the proper hospital facilities, treatment, and care.”<sup>39</sup>

Five months later, Sawyer sent a four-page letter to Sprague calling into question many of the claims the Legion made during the past two years and, by extension, the hard-fought policy of building new hospitals. Sawyer alleged that “few” Americans maintained their unconditional sympathy for – and, he implied, willingness to spend money on – World War veterans. He conceded that current facilities in at least one VB district were not fireproof, per se, but added that hospitals “as a rule” were “very free from fire hazard” because they were always under the “watchful care” of attendants, nurses, and others. Only four times during his 25-year career running institutions, Sawyer said, had he witnessed hospital fires. Repeating conceptions that Legion officials and bureaucrats had fought to disprove during their previous year of advocacy work, Sawyer noted that he was “personally convinced that the peak of hospitalization has been passed,” and that it seemed to make sense to “use the hospitals we now have at our command.” There were more than 10,000 vacant beds in government owned hospitals, Sawyer reminded Sprague; before new beds were added to the system, patients should be offered existing ones. If questioning the veracity of Legion claims was not enough, Sawyer took his argument one step further, patronizingly telling Sprague, “I like your spirit, your determination, your enthusiasm, your interest...” but he urged the Legion leader to “think this subject all over... in an unbiased unprejudiced way.” Sawyer was opposed, he wrote, “to the domination of people outside of the government” exercising their influence. Perhaps most infuriating to the Legion leader, Sawyer questioned whether it was necessary to spend the money the organization had fought so hard to have allocated for hospital-building and improvement. He said he was relieved

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<sup>39</sup> "Letter from A.A. Sprague to Charles Dawes", February 18, 1922. Microfilms, Rehabilitation – Veterans' Administration Hospitals – Hospitalization (con't) Rehab – VA – Hospitals – Survey 1929 Library 92-1012, American Legion Library, Indianapolis, Indiana.

that it was “not mandatory” to use the millions of dollars appropriated by the Langley Bill: “Just because we have money is no reason why we should waste it,” Sawyer wrote.<sup>40</sup>

The Sawyer letter was, in essence, an expression of a power struggle between government officials and interest groups. It was also remarkable in its tactlessness; it was pedantic and demeaning. By calling the need for hospitals into question, it seemed to suggest that the Legion’s hard-fought legislative victories were for naught. Definitive policy, Sawyer suggested, was still up for debate, subject to the personal whims of individuals like him, who could be appointed at any time to be involved in the planning process.

Sprague’s quick, fierce response railed against almost every one of Sawyer’s claims. Americans still stood firm behind Great War veterans, he said, and Sawyer’s suggestion otherwise was “an indictment of every American citizen.” He took issue with Sawyer’s suggestion that outside interest groups wielded too much power in Washington. After all, he said, it was thanks to the Legion that legislation was passed correcting the “miserable neglect” of disabled ex-service members. Sprague also rejected Sawyer’s reiteration of the already discredited idea that veterans should be placed in old army barracks or national soldiers’ homes. Ten thousand neuropsychiatric patients especially, he said, could not just make do “with any arrangement.” Veterans’ hospitals were “needed now,” Sprague said, questioning why facilities could be provided immediately when it came to treating soldiers at the front, but were so delayed when it came to treating ex-service members after the war. As more days passed without the availability of adequate facilities, Sprague said, men with shell-shock were less likely to be cured, and more likely to need lifelong institutional care. In this light, Sprague took the

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<sup>40</sup> "Letter from Charles Sawyer to A.A. Sprague, July 1922", July 12, 1922. Microfilms, Rehabilitation – Veterans' Administration Hospitals – Hospitalization (con't) Rehab – VA – Hospitals – Survey 1929 Library 92-1012, American Legion Library, Indianapolis, Indiana.

opportunity to call Sawyer's credibility and credentials into question. Before assuming leadership of the Federal Board of Hospitalization, Sprague scathingly said, "you had no contact with the men and women who were serving in the army and navy... no experience either in the field or government service that would give you a chance to really know how men feel who lose their nerve, their health and their minds in their devotion to duty..." He reminded Sawyer that experts had estimated that the peak of hospitalization would not be reached until 1926. "It is almost unbelievable," Sprague said, "that having satisfied Congress that these hospitals were needed and that they should be built to capacity that we now have to reply to your statement that they are unnecessary." He ended with the plea that Sawyer "stand aside," and give full autonomy to Charles Forbes, Director of the Veterans' Bureau, so the hospital program could move forward.<sup>41</sup>

Sprague released portions of both his and Sawyer's letters in an editorial, which was published in newspapers throughout the country. In New York, Iowa, Washington, DC, Missouri, Illinois, Pennsylvania, Tennessee, and Florida, articles appeared about the controversy, a great many of them trumpeting Sprague's position. Under banner headlines such as "Sawyer told to aid vets or quit," editorial writers noted that the "storm of protests over the bungling of Brigadier General Sawyer... must have some basis." Sawyer was "no doubt a darn good doctor in his own home town," the *Burlington Iowa Gazette* reported, but he had undoubtedly gained power not because of his credentials but because "the President wanted to do something extraordinary for his friend." When it came to heading the Federal Board of Hospitalization, the *Gazette* said, Sawyer had "fallen down on the job." C. Hamilton Cook, National Commander of

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<sup>41</sup> "Letter from A.A. Sprague to Charles Sawyer", July 20, 1922. Microfilms, Rehabilitation – Veterans' Administration Hospitals – Hospitalization (con't) Rehab – VA – Hospitals – Survey 1929 Library 92-1012, American Legion Library, Indianapolis, Indiana.

the Disabled American Veterans, also bolstered the Legion's claim by repeating Sprague's argument that Sawyer was holding up progress. "We want conditions to be such that Colonel Forbes (the director of the VB) will be responsible for anything and everything pertaining to the disabled men," Cook told the *New York Post*.<sup>42</sup>

The Legion's public relations campaign did not stop at sending press releases to newspapers; national officers sent telegrams to state offices, which in turn contacted local chapters, to urge them to get into the fray. Joe Sparks, a Legion liaison representative based in Georgia, was an especially eager participant. He shot off a letter to Georgia's state adjutant suggesting he "get men at Augusta to pass a resolution giving Sawyer HELL, and wire it to Washington [*emphasis in the original*]." Sparks also wrote to congressional representatives telling them that Sawyer was "blocking" the government hospital program for disabled ex-service men. Various representatives and senators responded with the assurance that they had the best interests of disabled ex-service men foremost in mind, though they abstained from joining in critiquing Sawyer.<sup>43</sup>

Perhaps that was because President Harding himself, as well as other notables, stood firmly behind the Ohio physician. Although Harding showed some willingness to accommodate ex-soldiers' demands by, for example, forming the Dawes and White Committees to decipher problems in the administration of medical care, he had a long history of skepticism toward many veterans' benefits. In the summer of 1921, just as legislation to establish the Veterans' Bureau

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<sup>42</sup> The referenced headline is from "Sawyer Told to Aid Vets or Quit," *The New York Times* August 30, 1922. The quoted text is from "Bungling of Sawyer," *Burlington Gazette* July 28, 1922. Also, "Oust Sawyer, Say Maimed Veterans," *New York Post* July 27, 1922. These and other newspaper stories concerning the controversy can be accessed in Microfilms, Rehabilitation – Veterans' Administration Hospitals – Hospitalization (con't) Rehab – VA – Hospitals – Survey 1929 Library 92-1012, American Legion Library, Indianapolis, Indiana.

<sup>43</sup> The Sparks letters are in *Ibid*.

was being debated, Harding took a strong stance against an adjusted compensation bill that would have provided cash payments to World War I soldiers. He made a bold move in personally addressing the Senate to report his belief that, “the enactment of the compensation bill... would... greatly imperil the financial stability of our country.” He referred to the push for a bonus as a “menacing effort to expend billions in gratuities” that would lead to a “treasury breakdown.” In the same address, Harding noted the many efforts that had been undertaken on behalf of World War veterans, including the provision of hospital care. In spite of the fact that there were 6,000 empty beds in government hospitals, he said, there had been much “progress made toward the construction of additional Government hospitals, not because we are not meeting all demands, but to better meet them and the better to specialize in the treatment of those who come under our care.”<sup>44</sup> World War veterans, Harding suggested, were getting plenty from their government.

About a year later, when the Legion-Sawyer controversy was in full swing, *The New York Times* and *Washington Post* reported that a White House spokesman said Harding would “not necessarily be subject to the will of the American Legion or any one else, but governed entirely by what he considers in the best interest of the former service men.”<sup>45</sup> *The Sioux City Iowa Journal* rightfully pointed out that “the president’s well-known loyalty to his friends will hardly permit him to displace General Sawyer,” and that the most the Legion could hope for was a

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<sup>44</sup> "The President's Address on the Bonus Bill," *The Baltimore Sun* July 13, 1921. Harding's personal visit to the Senate was attacked by some as over-reaching, but seen by others as a justified move against an all-too-powerful veterans' lobby. See, for example "President Harding Warns Senate of Soldier Bonus Bill Danger," *Los Angeles Times* July 13, 1921. "Harding Urges Delay on Bonus," *Boston Daily Globe* July 13, 1921. "No Bonus Now; Load Too Big, Harding Says," *Chicago Daily Tribune* July 13, 1921. For background on Harding's stance on adjusted compensation, see John W. Dean, *Warren G. Harding*, ed. Arthur M. Schlesinger Jr., American Presidents Series (New York, New York: Holt, Henry and Company, Inc., 2004), 108.

<sup>45</sup> "Harding Won't Change War Hospital Policy," *The New York Times* July 29, 1922. "Veterans' Interests to Be Harding's Guide," *The Washington Post* July 29, 1922.

“hastening of the hospital program.”<sup>46</sup> Charles Dawes, who Sprague had corresponded with in February 1922, also came to the defense of his administration colleague. “The practice of many government officials ‘to run to cover whenever Legion men give a blast’ and to change their plans to avoid public condemnation has been responsible for much unnecessary delay, waste and lessened efficiency in relief work,” Dawes told *The New York Times*.<sup>47</sup> According to the Journal of the Institute of Homeopathy, of which Sawyer was president, President Harding was “standing back of General Sawyer and says that the program which has been carried out is his and he should be blamed, not General Sawyer.”<sup>48</sup>

At an August 9, 1922 meeting of the Federal Board of Hospitalization, Sawyer defended himself against the Legion’s allegations and maintained his position regarding empty beds. Sawyer told his fellow board members he was regretful that the Legion controversy had garnered so much public attention. He said he received as many as 30 letters from Legion representatives. Because he ignored them, Sawyer surmised, Sprague’s hostility increased: he “picks up every side issue he possibly can,” Sawyer said of Sprague. As for the letters published in the press during the previous weeks, the president’s doctor argued that the Legion leader sent them to newspapers before he even received them. Sawyer stood by his original idea of offering empty beds to patients. If they refused them, he said, “then the burden of this whole matter is upon their shoulders.” Both Charles Forbes of the VB and William C. White, of the White Committee, took issue with Sawyer’s argument in the same respect as Sprague and others had in the past; they

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<sup>46</sup> "The Legion and Gen. Sawyer," *Sioux City Iowa Journal* July 28. 1922.

<sup>47</sup> "Dawes Backs up Sawyer," *The New York Times* July 30, 1922.

<sup>48</sup> "American Institute of Homeopathy Journal Editorial". Microfilms, Rehabilitation – Veterans' Administration Hospitals – Hospitalization (con't) Rehab – VA – Hospitals – Survey 1929 Library 92-1012, American Legion Library, Indianapolis, Indiana.

reminded him that three types of cases – neuropsychiatric, tuberculosis, and general medical and surgical – each required different types of beds.<sup>49</sup>

In September and October 1922, the American Legion claimed victory in the battle with Sawyer. After a meeting between Harding, Sawyer, Sprague, and other Legion representatives, the organization released a statement saying Sawyer agreed with the Legion's program for "the removal of the mentally unsound men from contract institutions to government owned and operated hospitals." The Federal Board and Legion would henceforth work in "close cooperation," Sprague reported.<sup>50</sup>

In spite of the impression given by newspaper coverage, Sawyer's statement did not mark a sentiment of acquiescence. In his very first letter to Sprague, Sawyer suggested moving veterans from contract institutions to government-owned hospitals, and working with the Legion to accomplish mutual goals. "Why not get our forces together..." he had asked Sprague.<sup>51</sup> Although the Legion claimed that Sawyer had yielded to their demands, his later actions did not represent much of a tide change from his original endorsement of the idea of moving veterans from private contract institutions to government-owned military and naval facilities.

In any case, the peace between the AL and Sawyer did not last long. At the Legion's national convention in New Orleans in October 1922, a member of the rehabilitation committee tried to set a harmonious tone. Noting the fact that Sawyer had stated his agreement with the Legion program, and his intention to cooperate with the organization, the committee

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<sup>49</sup> "Minutes of the Twenty-First Meeting of the Federal Board of Hospitalization", August 9, 1922, 6-7. Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans Bureau, 1917-1923, Record Group 90, Box 6, NC-34 Entry 23, National Archives and Records Administration, College Park, Maryland.

<sup>50</sup> "Sawyer Yields to Legion Plan for Service Men," *Chicago Daily Tribune* September 28, 1922. "Sawyer Agrees with Legion on Hospital Plans," *New York Tribune* September 28, 1922.

<sup>51</sup> "Letter from Charles Sawyer to A.A. Sprague, July 1922".

representative proposed a resolution endorsing “relations” with the Brigadier General. Although the Legion would maintain its “constructively critical attitude” toward the federal government, it would “accept for the time being the pledge of cooperation.”<sup>52</sup>

In response, a Legion representative from Minnesota proposed a decidedly less diplomatic resolution. It noted that in the four years that had passed since the Armistice, “vast sums” of money had been appropriated by Congress for hospital care, but Charles Sawyer had:

hampered the efforts of the Director of the Veterans’ Bureau... shown an utter inability to understand the necessity of immediate action... repeatedly made public statements which can only be construed to mean that he is more interested in economy than in saving the lives of the men who gave their health to their country, has in public statements shown his complete ignorance of existing conditions... and has shown himself by speech and action to be temperamentally unfitted for the position which he holds and for the responsibilities which he exercises...”

Sawyer, the resolution contended, should be removed from his position as Chief Coordinator of the FBH.<sup>53</sup>

A member of the rehabilitation committee spoke up strongly against the hostile resolution. The Legion should remain focused on the goal of improving hospital care, he argued: “While we quarrel, while we demand somebody’s resignation, somebody is suffering.” A representative from California said that if the resolution was passed, “we can expect little from Washington.” A fellow representative concurred. If the Legion demanded the removal of Sawyer, and Harding refused – which most involved in the discussion realized was a likely outcome – “where are we?” Sprague spoke up as well, saying that the Legion needed to work

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<sup>52</sup> "The American Legion, 1922 National Convention, Verbatim Minutes", October 16-20, 1922, 216-41. American Legion Library, Indianapolis, Indiana.

<sup>53</sup> Ibid.



with Sawyer as an ally; passing the resolution would not reflect badly on the president's physician, but instead on the National Rehabilitation Committee of the American Legion. This revelation led Sprague to strike a conciliatory tone regarding the battle that had ensued over the past year. The Legion, he said, had acted "possibly foolishly and in a mistaken manner."<sup>54</sup>

But Sprague's words failed to quell the anger fostered by months' worth of hostile editorials and statements. A Legion member from New York voiced his disgust with the lack of institutional care in his state. He was willing, he said, to "embarrass" the rehabilitation committee and Sprague, in order to help disabled veterans. The resolution should be passed, he exclaimed, and if Sawyer "bobs his head in this convention, let us smash it." The New York representative's sentiments carried the day; the resolution condemning the president's physician was passed with 601 in favor and 375 opposed.<sup>55</sup>

As it turned out, the predictions of those who spoke against the hostile statement proved correct. After the Legion convention, headlines reported "Harding Backs Sawyer's Acts" and "President Refuses to Oust Sawyer at Demand of American Legion."<sup>56</sup> Harding said he felt the organization's attacks were unfounded – based largely on the fact that he had approved plans for a hospital to be built at Camp Custer, Michigan instead of Sprague's hometown of Chicago – and that the President wished the Legion would "blame me, not Sawyer."<sup>57</sup> In fact, a White House

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<sup>54</sup> Ibid.

<sup>55</sup> Ibid.

<sup>56</sup> "Harding Backs Sawyer's Acts," *Los Angeles Times* October 25, 1922. "President Refuses to Oust Sawyer at Demand of American Legion," *The New York Times* October 25, 1922.

<sup>57</sup> "'Blame Me, Not Sawyer,' Legion Told by Harding," *Chicago Daily Tribune* October 25, 1922. One journal suggested that, in spite of the fact that the great majority of experts felt an Illinois site was preferable, politics won the day; the Camp Custer site was chosen so that Republican Senator Charles E Townsend, of Michigan, could use it as a selling point in his ongoing re-election bid. Richard Seelye Jones, "Politics and Disabled Soldiers," *The Spotlight* Volume VIII, Number 5(December 1, 1923).

spokesman said, Sawyer's Federal Board recommended that the veterans' hospital for the district comprising Wisconsin, Illinois and Michigan be located at Chicago, as the Legion hoped, but the President had pushed for it to be built at Camp Custer. Although the president steadfastly refused to remove Sawyer or acknowledge bureaucratic shortfalls, the episode did convince him that his administration should get "into close touch with veterans' affairs."<sup>58</sup> Still, in private correspondence, a Harding appointee noted "Mr. H. dislikes AL and resents attacks on S."<sup>59</sup>

It was questionable how much the Federal Board, or Charles Sawyer, had to do with the delays in new hospital construction in the first place. A central idea contained in Sawyer's original letter to Sprague – that beds should be used at a specific naval station before new institutions were built – was merely a reiteration of an idea first proposed by William C. White, of the White Committee, at a Federal Board meeting in June 1922.<sup>60</sup> Meanwhile, during these months, the FBH gatherings that Sawyer headed served as a meeting ground – and sometimes a contentious one – for the main players in veterans' hospital policy, but the group's actual powers and functions were being questioned in the winter and spring of 1922. Was it even a legal body? Did its powers stop at advisory? "If this Board has no legal existence it would only have authority in an advisory capacity, and the Director of the Veterans' Bureau could get your advice and then go on and do whatever he wanted to," board member and Commissioner of Indian

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<sup>58</sup> "Harding Won't Oust Sawyer," *Boston Daily Globe* October 25, 1922.

<sup>59</sup> Anthony, *Florence Harding: The First Lady, the Jazz Age, and the Death of America's Most Scandalous President*, 368.

<sup>60</sup> White suggested that the new Speedway Hospital and the Naval Training station be used "for the next few years for medical, surgical, and ambulant type of neuro-psychiatric cases – and then to build at the Naval Training station a unit of perhaps 500 beds to take care of the type of patients which have to be shut up and who are no longer in a condition for active treatment, and then gradually leave the mental and surgical, doing away with the various contract hospitals, and in that way build up the Neuro-psychiatric Center." "Minutes of the Eighteenth Meeting of the Federal Board of Hospitalization", June 12, 1922, 25. Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans Bureau, 1917-1923, Record Group 90, Box 6, NC-34 Entry 23, National Archives and Records Administration, College Park, Maryland.

Affairs, Charles H. Burke said to Sawyer at a February FBH meeting<sup>61</sup> As the controversy with the American Legion erupted, Burke declared that “this Board is in a position approaching the ridiculous.” Sawyer was being blamed for decisions regarding the location of hospitals made by Forbes, and the Board was being held responsible for mistakes in carrying out policy, when it was, in fact, only an advisory panel.<sup>62</sup> The problem of “divided authority” that Legionnaires and legislators hoped to be rid of with the creation of one overarching entity called the Veterans’ Bureau, apparently still existed.

Although the immediate results of the shaming of Charles Sawyer were somewhat muted – Sawyer maintained his position and the Legion remained a powerful lobbying force – the episode demonstrated that those who opposed, or questioned the rationale of making vast appropriations for veterans’ welfare, assumed a great political risk. Many bureaucrats and legislators never interrogated the idea of spending great sums on veterans’ hospitals, and genuinely believed it equated to good policy. Those who did harbor doubts about the Legion’s legislative agenda – those who held lesser offices than President Harding, and who did not enjoy virtually guaranteed job security, like Charles Sawyer – may not have been willing to endure the wrath of veterans’ advocacy groups, which could mobilize forces and undertake a “barrage” of publicity to perpetrate a very wide-ranging and personal attack.<sup>63</sup> In his role as director of the FBH, and by conceptualizing the Department of Public Welfare, Sawyer touted the merits of

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<sup>61</sup> "Minutes of the Twelfth Meeting of the Federal Board of Hospitalization", February 10, 1922, 3. Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans Bureau, 1917-1923, Record Group 90, Box 6, NC-34 Entry 23, National Archives and Records Administration, College Park, Maryland.

<sup>62</sup> "Minutes of the Twenty-First Meeting of the Federal Board of Hospitalization".

<sup>63</sup> The term “barrage” is used by William Pencak in reference to the techniques of the Legion’s National Legislative Committee head, John Thomas Taylor. “Opposing a Legion measure is like poking one’s political head out of a train window,” Taylor once said. Pencak argues that this was an “exaggerated” claim, but it still speaks to the perceived power of the veterans’ lobby, which was enough to keep some from disagreeing with the organization’s policies. Pencak, *For God and Country: The American Legion 1919-1941*, 117-22.

saving resources and eliminating waste. He and others who brought up reservations about the Veterans' Bureau and later, about vesting it with vast powers, often had their concerns silenced as advocates accused them of lacking concern for defenders of the nation's liberties.

*Scandal, the legacy of Charles R. Forbes, and "overhospitalization"*

The public outcry against Charles Sawyer helped divert attention from the apparent malfeasance of Charles Forbes, another Harding appointee of whom many were growing increasingly skeptical. Since soon after the VB's founding, Forbes had fought to keep a veterans' hospital building program free not only from the dictates of the Treasury Department's White Committee, but veterans' groups as well. In the winter of 1922-1923, frustration with – and eventually, suspicions of – the seemingly autocratic VB Director began to build.

Tensions mounted in the spring of 1922, when the transfer of facilities from the Treasury Department to the Veterans' Bureau allowed for plenty of federal spending and a vast expansion in the capacity of the VB, but very few tangible new beds. A White Committee report blamed Forbes, arguing that he had hampered the committee's efforts to provide fully functioning hospitals. Once President Harding transferred PHS supplies to the VB in April 1922, the report said, the Veterans' Bureau "refused the use of surplus supplies, and for weeks it was impossible to draw on supplies for equipment." The Committee was therefore forced to purchase equipment in order to complete Treasury hospitals before transferring them to the VB.<sup>64</sup>

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<sup>64</sup> Report of the Consultants on Hospitalization Appointed by the Secretary of the Treasury to Provide Additional Hospital Facilities under Public Act 384, 29-30. For more on the controversy over supplies, see: Equipment of Hospitals Transferred to Veterans' Bureau, Decisions of the Comptroller General of the United States, Volume 1, (Washington, D.C.: Government Printing Office, May 12, 1922), 650-52. Allotments of Appropriations to United States Public Health Service, Letter from the Director of the Veterans' Bureau, Transmitting, for the Consideration of the Senate, a Draft of Legislation Providing for the Making of Allotments of Appropriations by the United States Veterans' Bureau to the United States Public Health Service, Senate Document No. 204, Sixty-Seventh Congress, Second Session, (Washington, D.C.: Government Printing Office, May 18, 1922).

Forbes argued that the White Committee was obligated to use funding from the first Langley Bill in order to complete projects before handing them over to his bureau. "I had no way of foreseeing what shortcomings would result by reason of the hospitals constructed by the White Committee," Forbes wrote to the Legion's Albert A. Sprague, "They made their own plans and specifications and constructed their own hospitals." Furthermore, Forbes unapologetically noted, "it was not my intention nor would I under any consideration use any money of the second Langley Bill to complete and equip the hospitals that were turned over by the White Committee from the first Langley Bill."<sup>65</sup> One can surmise why veterans' groups and White Committee members began to suspect that Forbes was placing bureaucratic and financial concerns above the supposed needs of veteran-patients.

Forbes and leaders of the American Legion had long harbored mixed feelings towards each other, but they maintained cordial relations out of necessity. Veterans' groups were openly disappointed when Harding appointed a friend with experience in the construction industry, rather than an expert in ex-soldiers' affairs, as director of the Veterans' Bureau. At a January 1922 meeting of the Federal Board for Hospitalization, Forbes made it clear that he had his own doubts about the Legion and its counterparts. Discussing delays in hospital construction, he noted his belief that "the whole trouble is that about fifteen different ex-soldier organizations are opposing every hospital plan suggested by any organization other than the White Committee, which was backed up by the American Legion."<sup>66</sup>

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<sup>65</sup> "Letter from Charles Forbes to A.A. Sprague", August 24, 1922. Microfilms, Rehabilitation – Veterans' Administration Hospitals – Hospitalization (con't) Rehab – VA – Hospitals – Survey 1929 Library 92-1012, American Legion Library, Indianapolis, Indiana. For more on controversies re

<sup>66</sup> "Proceedings of the Federal Board of Hospitalization (Addendum to Minutes of Eleventh Meeting of the Federal Board of Hospitalization)".

In spite of those sentiments, Forbes took the time and effort to explain himself to the Legion. In August 1922, he wrote to Sprague to report that he felt that the hospital sites recommended by the White Committee were insufficient. He had therefore taken it upon himself to develop new plans, which would provide more beds.<sup>67</sup> Instead of building the facilities one at a time, he thought it “more advisable to proceed with the construction of the total number of hospitals with a smaller bed capacity... making the money go as far as possibly (*sic*)... then once construction is far enough along so that I can see just how far the funds are carrying us, I will be able to ask Congress for more funds if they deem them necessary.”<sup>68</sup> In other words, Forbes’ plan was to undertake a variety of projects, entangling government funds in each, so that Congress would eventually be all but forced to approve funding to complete each hospital.

One might think, from the perspective of advocates who only wished to have more and higher-quality beds available, that it could seem a brilliant strategy. But Sprague was skeptical of Forbes’ efforts. If the funds allotted for hospitals were insufficient, he said, the Director of the Veterans’ Bureau should “not... delay the presentation of actual needs to Congress.” “Out of this new quicksand of difficulties,” Sprague wrote, “we must take another step at once and go all the way to solid ground.”<sup>69</sup> Legion officials were evidently perturbed by Forbes’ lack of concern with the fact that, throughout the time of political wrangling, none of the institutions would be ready to receive patients.

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<sup>67</sup> "Letter from Charles Forbes to A.A. Sprague".

<sup>68</sup> "Letter from Charles Forbes to A.A. Sprague", August 14, 1922. Microfilms, Rehabilitation – Veterans' Administration Hospitals – Hospitalization (con't) Rehab – VA – Hospitals – Survey 1929 Library 92-1012, American Legion Library, Indianapolis, Indiana.

<sup>69</sup> "Letter from A.A. Sprague to Charles Forbes", September 12, 1922. Microfilms, Rehabilitation – Veterans' Administration Hospitals – Hospitalization (con't) Rehab – VA – Hospitals – Survey 1929 Library 92-1012, American Legion Library, Indianapolis, Indiana.

The correspondence between Forbes and Sprague reveals two things. First, Forbes could not win. Advocates were disappointed by the fact that more and better hospital beds were not available within a relatively short time. In many ways, Forbes (like officials of the BWRI and PHS before him), was being blamed for problems arising from pre-war plans gone awry and ever-expanding expectations of the responsibilities of government. The correspondence also reveals that suspicions of the VB Director were growing. Veterans' groups and others questioned how and why government funding was being spent, but facilities remained insufficient. Increasingly, they suggested that Forbes' own impropriety was to blame.

Within the Harding administration, some were beginning to suspect that Forbes' motives were less than genuine. As rumors flew about embezzlement and corruption, Florence Harding, who hoped to keep intact her reputation as an advocate for disabled veterans, asked friends who worked for the VB to keep her informed about inter-organizational activities. The First Lady had heard reports of Forbes taking cross-country "junkets," during which he and his traveling companions enjoyed "a constant flow of liquor, movie stars as party guests, and occasional swims in full evening dress." Beyond the fun, Forbes was allegedly engaging in outright graft by awarding government contracts to firms who granted him personal loans. In August 1922, he reportedly sold government supplies he claimed were damaged from a storage site at Perryville, Maryland to associates for a fraction of their actual cost. Around the same time, he loaded into Perryville supplies he purchased new with government funds for more than they were worth. Forbes reportedly received kickbacks on both ends of the deal.<sup>70</sup>

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<sup>70</sup> Forbes' corruption is widely cited as one of the defining scandals of the Harding administration. The quotes here are from Anthony, *Florence Harding: The First Lady, the Jazz Age, and the Death of America's Most Scandalous President*, 368-71. Also see, Payne, *Dead Last: The Public Memory of Warren G. Harding's Scandalous Legacy*, 59-60. Jr. Charles L. Mee, *The Ohio Gang: The World of Warren G. Harding* (New York, New York: M. Evans and Company, Inc., 1981), 147-55. Wilson, *The Presidency of Warren G. Harding*, 181-82. Kathleen J. Frydl, *The G.I. Bill* (New York, New York: Cambridge University Press, 2009), 49-50. One Congressional report describes the reign of Charles Forbes as "one of the most regrettable periods in the history of veteran care." R.E. Adkins, Medical

Throughout the summer and fall of 1922, it was not just the Legion and Florence Harding who were keeping an eye on Forbes. Charles Sawyer, too, was growing increasingly skeptical and “spying” on his colleague, who was absent from a fair number of FBH meetings in late 1922.<sup>71</sup> On one occasion, a Veterans’ Bureau executive officer, T. Hugh Scott, transmitted to Sawyer a copy of one of the Federal Board’s reports, marked with question marks and notes, that was “found in Colonel Forbes’ desk.”<sup>72</sup> A few months after forwarding on the report, Scott was transferred from his post in Washington, DC, to a VB hospital in Muskogee, Oklahoma. As the extent of VB corruption became clear shortly before Forbes’ resignation in early 1923, one journal reported a suspicion that the transfer was a sort of punishment for Scott’s reconnaissance work: “Perhaps T. Hugh Scott of Oklahoma, who took straight to the White House some accounts of things done and left undone, will tell how he was shifted overnight from high authority in Washington to exile at a distant hospital.”<sup>73</sup>

As tensions built, Forbes became somewhat defiant. When the matter of the Perryville sales came up at an FBH meeting in December 1922, for example, Charles Sawyer stated his belief that it had been a great mistake to sell the supplies instead of keeping them on hand for future use. Forbes responded that if he was to continue as the head of the VB, it was necessary

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Care of Veterans, Printed for the House Committee on Veterans Affairs Ninetieth Congress, First Session, (Washington, DC: Government Printing Office, April 1967).

<sup>71</sup> "Minutes of Various Meetings of the Federal Board of Hospitalization". Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans Bureau, 1917-1923, Record Group 90, Box 6, NC-34 Entry 23, National Archives and Records Administration, College Park, Maryland. Carl Sferraza cites correspondence regarding Sawyer’s spying: Anthony, *Florence Harding: The First Lady, the Jazz Age, and the Death of America's Most Scandalous President*, 368.

<sup>72</sup> "Letter from T.H. Scott to Charles Sawyer", August 31, 1922. Records of the Office of Management and Budget, Records of the Federal Board of Hospitalization, Record Group 51, Box 15, Entry 3, National Archives and Records Administration, College Park, Maryland. Jones, "Politics and Disabled Soldiers."

<sup>73</sup> "Dr. Scott Did Not Resign from Veterans' Bureau," *Journal of the American Medical Association* Volume 80, no. Number 10 (1923).



for everyone concerned to understand that “the internal management of the bureau was his responsibility only.”<sup>74</sup>

Within just a few months, however, the suspicions of the Legion and others led Congress to open an investigation into the VB.<sup>75</sup> As news of the probe trickled out of Washington, Forbes resigned from his post. “There is little understanding of the magnitude of this task, and there is little appreciation of the splendid service of its employes (*sic*) in the interest of the disabled men,” he said in a statement immediately following his resignation in February 1923.

Inefficiencies in his bureau, he maintained, were due to attempts by unnamed parties to “inject politics,” in part by ensuring that only Republicans were hired for available jobs. Slighting the accomplishments and potential of the already existent White Committee and Federal Board of Hospitalization, Forbes also argued that a “board of consultants” should be “on duty at the central office” to advise the VB Director, and paid salaries commensurate with their professional experience.<sup>76</sup>

In 1924 and 1925, a congressional investigation and a subsequent grand jury trial found that Charles Forbes had defrauded the government – and, by extension, the veterans he was meant to serve – out of millions of dollars. Forbes’ denial of all charges and his claim that Charles Sawyer and other witnesses who testified against him were undertaking a politically

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<sup>74</sup> "Summary of Matters Presented at Meeting of Federal Board of Hospitalization", December 4, 1922. Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans Bureau, 1917-1923, Record Group 51, Box 1, Entry 3, National Archives and Records Administration, College Park, Maryland; "Memorandum to General Sawyer from Surgeon General H.S. Cumming", December 18, 1922. Records of the Public Health Service, Correspondence with War Risk Insurance Bureau and Veterans' Bureau, 1917-1923, Record Group 90, Box 5, NC-34, Entry 23, National Archives and Records Administration, College Park, Maryland.

<sup>75</sup> On March 2 1923, the Senate adopted a resolution providing for a committee of three senators – David Walsh of Massachusetts, David A. Reed of Pennsylvania, and Tasker L. Oddie of Nevada – to oversee an investigation of the Veterans’ Bureau. On the same day, Forbes resigned as Director of the agency. Senate Resolution 466, Sixty-Seventh Congress, Fourth Session, (Washington, D.C.: Government Printing Office, March 2, 1923).

<sup>76</sup> "Hines Chosen Head of Veteran Bureau," *The New York Times* February 28, 1923.

motivated conspiracy came to naught: he was sentenced to serve two years at the Leavenworth Federal Penitentiary.<sup>77</sup> Frank T. Hines, who replaced Forbes as head of the VB, made it his mission to ensure that the Bureau would not only be a model of administrative efficiency, but would also continue to grow.<sup>78</sup> In the short-term, it seemed the Legion's push for the creation of a Veterans' Bureau, with an all-powerful director, had backfired.

But Forbes' eager aggressiveness in expanding his agency's power and institutional girth – whatever his underlying motivation – had a lasting effect quite apart from the scandal: it served as a primary factor in the early expansion of the Veterans' Bureau hospital system. It is debatable whether, without the efforts of Charles Forbes, an autonomous veterans' hospital system would have emerged after World War I. Had he not tried to usurp power from the Department of the Treasury over PHS facilities, and pursue a building program under the auspices of the VB, veterans may have been housed in facilities owned by a variety of federal entities, which would have eventually reverted to the auspices of previously existing government branches. Instead, in

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<sup>77</sup> The investigation and trial, which included gripping accounts of Forbes' fondness for parties and liquor, as well as an extra-marital affair between the former VB Director and the wife of one of his accusers, were widely covered by the national press corps. See, for example: "Intrigue, Debauchery, Corruption Are Charged against Former Director of Veterans' Bureau," *The Atlanta Constitution* October 25, 1923. "Claims Forbes Tried to Change Dope into Gold," *Chicago Daily Tribune* October 30, 1923. "Forbes Accuses Foes of Perjury and Conspiracy," *Chicago Daily Tribune* November 14, 1923. "Charles Forbes Blames Sawyer And 'Politics'," *The Atlanta Constitution* November 14, 1923. "Forbes in Grafting Ring, Says O'ryan," *The Baltimore Sun* November 16, 1923. "Charles Forbes Split Profits with Builders," *Chicago Daily Tribune* February 8, 1924. "Start Trial of Forbes Here in April, U.S. Plan," *Chicago Daily Tribune* March 2, 1924. "Mortimer's Story Is Controverted; Stenographer Denies Either Mortimer or Thompson Was in Hotel at Time of Transaction," *The Atlanta Constitution* December 19, 1924. "Forbes Witnesses Assail Mortimer," *The New York Times* December 30, 1924. "Forbes Won over Army Engineers," *Boston Daily Globe* January 6, 1925. "Forbes Fails to Take Stand; Defense Claims Its Case Complete Without," *Boston Daily Globe* January 22, 1925. "Forbes Given Two Years in Prison," *Boston Daily Globe* February 4, 1925. "Forbes Looks to High Courts; Will Fight Guilty Verdict 'To Last Ditch'," *Boston Daily Globe* February 5, 1925.

<sup>78</sup> Among other things, Forbes was accused of selling government property at well below cost to personal friends, getting kickbacks for accepting bids on new hospital sites, and selling hospital sites at inflated prices to reap his own financial rewards. According to one scholar, Forbes' misdeeds cost taxpayers around \$200 million, and his appointment constituted "one of Harding's worst misjudgments." Wilson, *The Presidency of Warren G. Harding*, 181. For other accounts of the scandal, see: Stevens, "The Invention, Stumbling, and Re-Invention of the Modern U.S. Veterans Health Care System, 1918-1924."; Charles L. Mee, *The Ohio Gang: The World of Warren G. Harding*, 148-55. Dean, *Warren G. Harding*, 139-40.

part thanks to Forbes' influence, a vast system of hospitals was controlled by the VB, and accessible specifically and indefinitely, for veterans.

In the spring of 1923, the White Committee submitted its final report and exited the field of veterans' hospital policy and planning. The Veterans' Bureau had gained control over the task of locating veterans' hospitals, and the Federal Board of Hospitalization had assumed the responsibility of coordinating all federal hospital activities.<sup>79</sup> The passing of the White Committee represented a larger pattern: the end of an era when social reformers and medical experts dominated policy-making. In the post-war years, as the Progressive Era trend of expert committees waned, government bureaucrats and advocates, as opposed to reformers and doctors, dictated policy.<sup>80</sup> It also marked the beginning of an era of fruitful cooperation between the Veterans' Bureau, veterans' advocates, and legislators.<sup>81</sup>

In spite of facing many challenges during its 20-month existence, including inter-departmental transfers of power and administrative problems within the VB, the White Committee forged ahead with its mission to recommend a comprehensive national building

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<sup>79</sup> In one of its very first meetings, in fact, the latter organization had recommended the dissolution of the White Committee, since "there should not be two organizations dealing with this subject." "Summary of Matters Presented at Meeting of Federal Board of Hospitalization", October 2, 1922. Records of the Federal Board of Hospitalization, General Records, 1921-1948 Record Group 51, Box 15, Entry 3, National Archives and Records Administration, College Park, Maryland.

<sup>80</sup> Beth Linker notes that the formulation of the War Risk Insurance Act at the beginning of the war "took veterans' legislation out of the hands of interest groups and Congressional lawmakers and put it into the hands of Progressive reformers and social science experts." Beth Linker, *War's Waste: Rehabilitation in World War I America* (Chicago, Illinois: University of Chicago Press, 2011), 28. By war's end, the trend had gone full circle; veterans' legislation was, once again, highly influenced by veterans' groups. For more on medical experts, the White Committee, and the FBH, see Rosemary A. Stevens, "Can the Government Govern? Lessons from the Formation of the Veterans Administration," *Journal of Health Politics, Policy and Law* Vol. 16, no. 2 (1991): 283-98. Stevens argues that that the assignment of power to medical professionals of the White Committee, "could be seen either as a progressive, top-down, prescriptive response to social policy, or as a convenient political sleight of hand." Stevens, "The Invention, Stumbling, and Re-Invention of the Modern U.S. Veterans Health Care System, 1918-1924."

<sup>81</sup> The collaboration of these three entities is often referred to as an "iron triangle," a concept discussed in Chapter Five, and later in this chapter.

program for veterans' hospitals. By 1923, based on the suggestions of the consultants, work was mostly complete on 19 hospital projects designed to provide approximately 6,000 beds for veterans. Four new hospitals were constructed, three were purchased and later remodeled, and twelve were transferred from the PHS or War Department, or were additions to existing National Homes for Disabled Soldiers.<sup>82</sup>

In a November 1923 report, the White Committee recorded its frustration with what it viewed as separatism and redundancies on the part of the Veterans' Bureau. In response to Charles Forbes' repeated claims that the White Committee was inefficient and wasteful, the report pointed out that 18 months after the April 1922 passage of the second Langley Bill, the Veterans' Bureau had provided only 200 new beds for occupancy, and those were "at a hospital in Memphis, Tennessee, which was purchased completely equipped, and ready to operate." Furthermore, the VB had completed only an average of 68 percent of the thirteen hospital projects it had started. On the other hand, the efforts of the White Committee had, after just 18 months, allowed for the provision to the VB of more than 2,900 beds (many of them, the report neglected to mention, in previously existing institutions), and completed 84 percent of its "total program." By May 1924, the White Committee report said, more than 5,800 completed beds would be turned over to the VB, thanks to the efforts of the Treasury Department.<sup>83</sup>

The White Committee used its final report to bring up a thorny question: had the government fostered "overhospitalization"? \$316 million had been spent on hospital construction since 1917, the report pointed out, "a great deal" of which was "spent for temporary hospitals

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<sup>82</sup> "Delays in Hospital Construction, Conclusions", August 22, 1922. Records of Collaborating Boards and Committees, Board of Consultants on Hospitalization, General Correspondence and related records, 1921-23, Record Group 121, Box 27, Entry 164, National Archives and Records Administration, College Park, MD.

<sup>83</sup> Ibid.

established during the war which had to be abandoned.” Getting to the supposed root of the problem, it noted: “If the United States Government had had a Federal plan for its hospital work, probably much that was otherwise wasted could have been preserved as permanent institutions for use in the situation that confronts the country to-day.”<sup>84</sup> Following the release of the White Committee report, newspapers echoed the sentiment: “Charge huge waste in hospitalization,” read a *Washington Post* headline. “Medical Experts Find U.S. Built Many Institutions that will not be needed.”<sup>85</sup>

Although it was politically expedient – and, in part, accurate – to cite previous policy oversights as the culprit for later wastefulness, planning efficiently for the provision of hospital care for veterans was problematic for a variety of reasons. Because of the unpredictable and chronic nature of two widespread conditions of World War I former soldiers – tuberculosis and mental illness – it was, according to the White Committee, “impossible... to give accurately the numbers of (veteran) beneficiaries in order to get a true idea of how many beds were needed.” According to the committee, “actual practice,” had shown the figures it originally used in order to estimate the necessary number of beds to be “too high.”<sup>86</sup>

Another reason why organizing a hospital system was challenging, and haphazard growth occurred, was because it was difficult to assess how many beds were actually in existence and useful at any given time. For example, in January 1922, the White Committee recommended that

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<sup>84</sup> Report of the Consultants on Hospitalization Appointed by the Secretary of the Treasury to Provide Additional Hospital Facilities under Public Act 384, 35.

<sup>85</sup> “Charge Huge Waste in Hospitalization,” *The Washington Post* March 21, 1923.

<sup>86</sup> Letter to the Secretary of the Treasury, Quoted in Report of the Consultants on Hospitalization Appointed by the Secretary of the Treasury to Provide Additional Hospital Facilities under Public Act 384, (Washington, D.C.: Government Printing Office, January 25, 1922). In 1921, the Committee had used as a guideline for its recommended hospital program House Document 481, which estimated that more than 30,000 beds would be necessary in order to provide for veteran-patients in the years to come. For more on H. Doc. 481, see Chapter Four of this dissertation.

a total of 20,000 beds be made available for veterans: 8,000 for patients with tuberculosis, 8,000 for patients with neuropsychiatric disease, and another 4,000 for general medical or surgical cases.<sup>87</sup> According to the 1922 annual report of the Veterans' Bureau, 27,985 government beds were available as of June 1922.<sup>88</sup> On the surface, it seemed simple enough that there was a surplus of more than 7,000 beds. But medical professionals joined veterans' advocates in pointing out that beds had to be of a certain quality and type, and in locations relatively close to veterans' homes. Also, they argued, tuberculosis and neuropsychiatric patients needed to be housed in buildings specially suited to their conditions; not just any empty bed would do. Neuropsychiatric patients posed a particularly vexing problem, and resources were especially scarce for their care. While the VB had successfully located more than 70 percent of both tuberculosis and general medical patients in government hospitals by June 1922, only 50 percent of neuropsychiatric patients were in government facilities by that time. Most of the new facilities proposed in 1921 and 1922 by Treasury Department and VB officials were aimed at alleviating that specific problem, even as other (unsuitable) government beds sat empty.<sup>89</sup> For members of Congress seeking to understand the problem at hand, it was challenging to get a handle on the actual numbers – of patients or necessary beds – involved. Eager to stave off reputations as anti-veteran, many reacted by simply granting more funding when it was requested.

The third reason why somewhat chaotic growth of hospitals occurred was because various government committees and organizations were operating at cross-purposes and in

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<sup>87</sup> Ibid; Report of the Consultants on Hospitalization Appointed by the Secretary of the Treasury to Provide Additional Hospital Facilities under Public Act 384.

<sup>88</sup> Annual Report of the Director, United States Veterans' Bureau for the Fiscal Year Ended June 30, 1922, 75.

<sup>89</sup> Brigadier General C.E. Sawyer, "Annual Report, Federal Board of Hospitalization, 1922". The FBH report notes that St. Elizabeth's was the only hospital to be operating at full capacity; each of its 878 beds were filled in late summer 1922 – a testament to the extent of need for beds for patients suffering from mental illness.

competition for resources. The White Committee moved forward on conceptualizing a national system of veterans' hospitals even as a new VB Director – initially, with the blessing of the Federal Board for Hospitalization – undertook a separate building program and strove for control over the system. In addition to pursuing new institutional projects, the White Committee and Forbes had to determine which, if any, military and Public Health Service hospitals being turned over to the Veterans' Bureau were suitable for occupancy by ex-soldiers. Both parties were propelled by veterans' groups, which argued consistently and forcefully that more and better facilities were necessary.

*“You are going to have a pension roll here that will make the pension roll of the Civil War look like a tip to the waiter”: The World War Veterans' Act and hospital access for all ex-service members*

One person who was not “greatly worried over the possibility of being overhospitalized” was the new VB Director, Frank T. Hines, who worked alongside advocacy groups to organize and further expand the veterans' hospital system following the Forbes scandal.<sup>90</sup> In fact, Hines and veterans' groups somewhat counter-intuitively argued, an overabundance of hospital beds indicated that an expansion in access to benefits was justified. One of the most lasting achievements of their efforts came on June 7, 1924, when the World War Veterans' Act (WWVA) was signed into law. The Act, which had the overarching goal of revising and clarifying aspects of legislation related to the functioning of the VB, had a dramatic effect on the nature of veterans' hospital care.

Previous legislation allocating funding for hospitals and creating the VB provided the framework necessary for the creation of a medical system intended solely for veterans. The

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<sup>90</sup> "Hospitalization Plan to Stand, Hines Says," *The Washington Post* March 22, 1923.

WWVA exponentially expanded the pool of potential beneficiaries who could access that system; it not only loosened restrictions regarding “presumed service connection” of illnesses such as tuberculosis, but also stipulated that *all* ex-service members and military nurses – regardless of how much time had passed since they were in the military, or the nature of their ailments – were eligible to receive care in veterans’ hospitals. “With one stroke of the pen,” Rosemary A. Stevens writes, “the original hospital and medical program, which had been designed as workers’ compensation, was translated into comprehensive hospital insurance.”<sup>91</sup>

In the months leading up to the proposal of the WWVA, access to VB benefits gradually expanded as legislators and veterans’ advocates attempted to answer a variety of difficult questions. When it came to medical conditions such as tuberculosis and neuropsychiatric illness, how could the ailment be definitively traced to service? How could the government know that a veteran who sought treatment for tuberculosis in 1922 did not have the illness prior to enlistment? Was the government obliged to treat such a veteran, even if the origins of his condition could not be traced directly to his time in the service? These were complex questions with somewhat subjective answers, and the World War I period was, in many ways, precedent-setting. In July 1919, access to vocational rehabilitation was granted not just to those who had incurred a disability in-the-line-of-duty, but to any ex-soldier whose disability was “incurred, increased, or aggravated while a member of such [military] forces, or later developing a disability traceable in the opinion of the board to service with such forces...” In 1923, benefits were further expanded when the War Risk Insurance Act was amended such that tuberculosis or neuropsychiatric disease causing more than ten percent disability would be presumed to be

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<sup>91</sup> Stevens, "Can the Government Govern? Lessons from the Formation of the Veterans Administration," 296.



service connected if they arose within three years of discharge from service.<sup>92</sup> These piecemeal legislative measures were spurred by administrative difficulties and strong advocacy efforts on the part of veterans' groups, and they helped pave the way for the broader changes contained in the World War Veterans' Act.

The Act's stipulation that all veterans could have access to government hospitals built not only on recent developments in veterans' benefits, but also on a deeper history. The notion of granting government benefits to veterans across the board, as opposed to by virtue of service-connected disability, was not new to the World War I era. Throughout the nineteenth century, what was intended as a small government pension program for indigent ex-soldiers swelled into the first major welfare system. Beth Linker points out that the Revolutionary War Pension Act of 1818 was initiated as a sort of poor law; by providing an "oath of indigency" ex-soldiers could receive annual payments between \$96 and \$240. Advocates successfully argued for passage of the legislation by estimating that no more than 2,000 veterans would file claims for pensions; in fact, the government received more than 20,000 requests for payments. In an attempt to narrow the pool of potential beneficiaries following the nation's next major war, the authors of the General Law of 1862 made pensions contingent on degree of disability resulting from service. Instead of proving he was destitute, a veteran had to supply affidavits from physicians and other

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<sup>92</sup> According to one legislative history of veterans' benefits, 1923 amendments to the War Risk Insurance Act, began "to lay the groundwork for a body of law that eventually would lead to presuming a service-connection that associated specific diseases and disorders with specific historic episodes of military service." Economic Systems Inc., V.A. Disability Compensation Program: Legislative History, (Washington, D.C.: V.A. Office of Policy, Planning, and Preparedness, December 2004), 37. A few months after the passage of the War Risk Insurance amendments, it was declared that all veterans drawing compensation for temporary disability were to be reexamined and, if possible, designated as permanently disabled. According to Walter Hickel, the move was motivated less by generosity than by administrative considerations; placing a veteran on permanent disability meant he did not have to be examined regularly. It also meant he might harbor more positive feelings toward the Bureau and the government. Within two years of the passage of the regulation, the percentage of beneficiaries with permanent disabilities had risen from 19 percent to 49 percent. K. Walter Hickel, "Entitling Citizens: World War I, Progressivism, and the American Welfare State, 1917–1928" (Ph.D. Dissertation, Columbia University, 1999 ), 136-46.

experts about his physical condition. Throughout the following decades, veterans' groups like the Grand Army of the Republic successfully lobbied for expansion of coverage; in 1873, ex-service members gained the right to compensation even if their injury or illness arose after service, and in 1890, they won access to pensions regardless of whether they could prove that their injuries or illnesses could be traced to their time in the military. Linker points out that the latter law (like preceding legislation aimed at expanding rights for veterans) faced staunch opposition from fiscally conservative Republicans and others. Offering privileges to the few on the backs of the many, they argued, was not only "an affront to social justice," but also could "'climax... in communism.'" <sup>93</sup> In the face of such critiques, the nineteenth century laws set a precedent that veterans could and should receive government payments by virtue of the fact that they had served. And their passage demonstrated the potential political power of a veterans' lobby. <sup>94</sup>

By the time the World War Veterans' Act came up for debate, the Veterans' Bureau had become a vast bureaucracy. Since its inception in 1921, the agency had disbursed more than \$40 million for hospital-related expenses. In January of 1924, it had 157,000 claimants and was paying for the care of more than 18,000 hospital patients: approximately 7,800 of them were being treated for tuberculosis, 6,200 for neuropsychiatric conditions, and 4,400 for general medical and surgical issues. <sup>95</sup> Between 1919 and 1921, advocates worked hard to ensure that

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<sup>93</sup> Linker, *War's Waste: Rehabilitation in World War I America*, 13-27.

<sup>94</sup> One's eligibility for benefits was, of course, dictated by official interpretations of the laws, which varied based on when and where an applicant submitted his claim. A January 1922 article in *Hospital Corps Quarterly*, pointed out confusing aspects of World War I-era laws related to pensions, and provided individual case studies in order to offer guidance on the question of when a veteran was eligible for benefits. Chief Pharmacist R.C. Rowe, U.S. Navy, "Line of Duty," *Hospital Corps Quarterly* Vol. 6(January 1922).

<sup>95</sup> Hearings before the Committee on World War Veterans' Legislation, House of Representatives, on Proposed Legislation as Recommended by the Director of the United States Veterans' Bureau and American Legion, Disabled American Veterans, and Veterans of Foreign Wars, 12-23. According to one newspaper article, the VB was mailing checks to veterans in more than 81 countries in early 1924. "Veterans' Bureau Mails Checks to 81 Countries", *The Washington Post* June 2, 1924.

former service members could receive proper care while remaining close to their loved ones. In so doing, they pushed for a Veterans' Bureau hospital system that consisted of relatively small institutions scattered throughout the country. By 1924, there were 44 Veterans' Bureau hospitals that specialized in tuberculosis, neuropsychiatry, or general medicine and surgery.<sup>96</sup>

Ironically, in the mid-1920s, the problem of a lack of beds had been replaced by the problem of the existence of what some said was too many beds. There were plenty of examples of supply – and provisions of previously approved hospital plans – exceeding demand. In February 1923, Goerge H. Wood, President of the Board of Managers of the National Home for Disabled Volunteer Soldiers, said the branches of his service did “not have the number of patients from the Veterans' Bureau” previously expected. For example, Wood said, a \$50,000, 1,000-bed annex had been built at the Western Soldiers' Home, in order to provide care for 200 Veterans' Bureau patients. Wood reported that he received a letter from Charles Forbes in July 1922 (once the building was complete) “cancelling all reservations.” Now, “Annex R” stood “completely closed, with no patients in it.” Wood surmised, “there is no demand in that district. In fact, I might say that the number of patients treated by the Veterans' Bureau has decreased in the last year, and has not increased, while the number of hospitals for their care has been so decidedly increased... that they have a superfluity of facilities.”<sup>97</sup> By January 1924, when the

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<sup>96</sup> Hearings before the Committee on World War Veterans' Legislation, House of Representatives, on Proposed Legislation as Recommended by the Director of the United States Veterans' Bureau and American Legion, Disabled American Veterans, and Veterans of Foreign Wars, 12. For more on VB hospitals in 1924, see Annual Report of the Director, United States Veterans' Bureau, for the Fiscal Year Ended June 30, 1924 (Washington, D.C.: Government Printing Office, 1924), 44-45.

<sup>97</sup> Statements of General George H. Wood, President, Board of Managers, Hearings Conducted by the Subcommittee of the Committee on Appropriations, House of Representatives, in Charge of the Third Deficiency Appropriation Bill for the Fiscal Year 1923, Sixty-Seventh Congress, Fourth Session, (Washington, D.C.: Government Printing Office, February 9, 1923).

World War Veterans' Act was under discussion, approximately 25 percent of the Veterans' Bureau's 16,000 hospital beds were empty.<sup>98</sup>

But the problem could not be summed up simply as over-supply. Demand for hospital services varied by locale, specialty, and – in the case of a diagnosis like tuberculosis – the season. So, while some facilities were sparsely populated, others were filled to capacity. Furthermore, although the number of neuropsychiatric patients in VB hospitals steadily increased between 1919 and 1924, the number of tuberculosis and general medical cases decreased overall during the same period.<sup>99</sup> In debates regarding the bill, advocates argued that huge numbers of empty beds had more to do with rules about disability ratings and diagnoses than they did with “overhospitalization,” or real levels of demand. There were plenty of veterans who needed treatment, said Frank Hines, Director of the Veterans' Bureau, but their claims were denied because their disabilities were not considered connected to service.<sup>100</sup>

Hines relied on a pragmatic argument to justify why veterans' hospitals should be opened to such patients: empty beds led to decreased efficiency; expanding access to more veterans was the most viable option for improving services across the board. “It is better if the government uses the facilities to their full load which you have spent some \$41,000,000 to build than to have

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<sup>98</sup> Hearings before the Committee on World War Veterans' Legislation, House of Representatives, on Proposed Legislation as Recommended by the Director of the United States Veterans' Bureau and American Legion, Disabled American Veterans, and Veterans of Foreign Wars, 12-14.

<sup>99</sup> Annual Report of the Director, United States Veterans' Bureau for the Fiscal Year Ended June 30, 1922, 24-46, see esp. p 31, 35. Annual Report of the Director, United States Veterans' Bureau, for the Fiscal Year Ended June 30, 1924 44.

<sup>100</sup> Hearings before the Committee on World War Veterans' Legislation, House of Representatives, on Proposed Legislation as Recommended by the Director of the United States Veterans' Bureau and American Legion, Disabled American Veterans, and Veterans of Foreign Wars, 47.

vacant beds,” he said.<sup>101</sup> In other words, Hines suggested, now that the veterans’ medical system existed, access to it had to be expanded in order for it to be efficient.

Providing access to more veterans made sense from an administrative standpoint as well, according to Edwin Bettelheim of the Veterans of Foreign Wars. He noted that the reviews of records necessary in order to prove service connection were time-consuming and costly. “We believe,” Bettelheim said, “rather than go through all the administrative work of investigating and segregating, (that the VB should) take care of the man as he comes knocking at your door.”<sup>102</sup> Treating all veterans who sought care, as opposed to only some, advocates counter-intuitively argued, would help alleviate wastefulness.

Bettelheim and others pragmatically declared that the neediest and most worthy cases would receive care first, and assured legislators that demand would remain manageable. Wasn’t it worth spending four or five million dollars per year, Bettelheim asked, “to take care of these men that will become a charge on some community”? Like those who argued in 1818 (inaccurately, as it turned out) that many ex-soldiers would choose not to capitalize on a granted benefit, Bettelheim suggested that it was illogical to assume that “veterans will be out and try to get all the hospital treatment they can.”<sup>103</sup> In fact, said the VB’s Frank Hines, a vast majority of the four million people who served during the war would “prefer to go to hospitals of their own

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<sup>101</sup> Ibid.

<sup>102</sup> Hearings before the Committee on World War Legislation, House of Representatives, on Proposed Legislation as Recommended by the Director of the United States Veterans' Bureau, the American Legion, Disabled American Veterans, and Veterans of Foreign Wars, and H.R. 7320, Part 2, Sixty-Eighth Congress, First Session, (Washington, D.C.: Government Printing Office, March 3, 1924), 553-56. Stephen Ortiz points out that in the early 1920s, the V.F.W. predominantly consisted of aged veterans of previous wars, and was eagerly “seeking to make inroads with Great War veterans” by supporting a great expansion of benefits. Stephen R. Ortiz, *Beyond the Bonus March and G.I. Bill* (New York, New York: New York University Press, 2010), 30.

<sup>103</sup> Hearings before the Committee on World War Legislation, House of Representatives, on Proposed Legislation as Recommended by the Director of the United States Veterans' Bureau, the American Legion, Disabled American Veterans, and Veterans of Foreign Wars, and H.R. 7320, Part 2, 553-56.

selection and under their own doctors.” He predicted that the number of people being discharged from veterans’ hospitals would balance the numbers being newly admitted, and that even once all veterans were granted the right to hospitalization, the patient load “will not, as we go along, be very much greater than the load we have carried in the past.” Hines went so far as to guarantee that no new facilities would need to be built as a result of the proposed legislation.<sup>104</sup>

Legislators rejected such optimistic forecasts, and voiced deep skepticism about the premise of the proposal. Above all, Republicans and Democrats alike were astonished by the sheer magnitude of the request. “Would it be true to say that we are adopting a new principle, if we establish the precedent of undertaking to furnish hospitalization for 4,000,000 of our people during the terms of their lives?” asked Robert Luce (R-MA). Alfred L. Bulwinkle (D-NC) was also baffled, and expressed the incredulity many Southern whites would doubtless harbor regarding such a request: “You do not recommend that every man who walks up to a hospital with a discharge in his hand with some ill, regardless of his financial standing, shall be admitted to that hospital?”<sup>105</sup> The measure would cost “billions of dollars,” said James H. MacLafferty (R-CA).<sup>106</sup> After all, he noted, “during a man’s life there would be a vast amount of sickness that could not be connected with the service...” Homer P. Snyder (R-NY) conceded that there was a “crying need” for better policy in the short-term, “but whether it should be carried to the extent

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<sup>104</sup> Hearings before the Committee on World War Veterans' Legislation, House of Representatives, on Proposed Legislation as Recommended by the Director of the United States Veterans' Bureau and American Legion, Disabled American Veterans, and Veterans of Foreign Wars, 46-47.

<sup>105</sup> Ibid., 45-46.

<sup>106</sup> Hearings before the Committee on World War Legislation, House of Representatives, on Proposed Legislation as Recommended by the Director of the United States Veterans' Bureau, the American Legion, Disabled American Veterans, and Veterans of Foreign Wars, and H.R. 7320, Part 2, 549.

of all time is another story.”<sup>107</sup> John E. Rankin (D-MS) was most definitive in his disapproval. “You are throwing the door wide open,” he told Bettelheim. “You are going to have a pension roll here that will make the pension roll of the Civil War look like a tip to the waiter.”<sup>108</sup> Luce questioned the contention that no new facilities would have to be built in order to fulfill the mandate in the proposed legislation: “Don’t you see, if we establish the principle of free hospitalization for all veterans, it would then be incumbent upon us to furnish the facilities therefor (*sic*), if the present facilities were not sufficient, and that involves a further building program.”<sup>109</sup>

Congressional representatives also disagreed on an ideological level with the proposal to provide free hospital care for all ex-service members. Rankin, like those who had fought against granting blanket pensions in the nineteenth century, argued that offering special treatment to ex-soldiers amounted to creating a privileged class. “Why limit it to soldiers?” he asked:

Why should we come up here 25 years after the war closes and say to this man... ‘you say you served a few weeks or months in the training camp. Of course you did not get across; you did not get hit. But you come up here 25 years after the war is over and you contract measles or you break your leg, and you can go into the hospital now and stay there the rest of your life.’ Because when you get them in there, believe me, there will be many a one who will stick. Here is another man who had a wife and children to support. He contributed whatever we required of him. He would have gone if the draft had demanded it. He is down and out, and has some incurable disease. Possibly he has reached the age of 70. You say to him, ‘oh no you are precluded from this.’ He is just as likely to become a public charge as I am. If you are going to put that on the ground that these men are likely to become a public charge, do not let us narrow it down to the men who have served a short time in the Army, Navy or Marine Corps.

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<sup>107</sup> Hearings before the Committee on World War Veterans' Legislation, House of Representatives, on Proposed Legislation as Recommended by the Director of the United States Veterans' Bureau and American Legion, Disabled American Veterans, and Veterans of Foreign Wars, 48.

<sup>108</sup> Hearings before the Committee on World War Legislation, House of Representatives, on Proposed Legislation as Recommended by the Director of the United States Veterans' Bureau, the American Legion, Disabled American Veterans, and Veterans of Foreign Wars, and H.R. 7320, Part 2, 556.

<sup>109</sup> *Ibid.*, 553.

Doubtless sensing the hostility of his audience, Bettelheim refrained from arguing that veterans were more worthy of federally sponsored hospital care than others. The legislation in question was a “veterans’ proposition,” he said simply, “and it is not our province to advocate something for others.”<sup>110</sup>

Robert Luce shared Rankin’s sentiment, but was most perturbed by the degree of government intervention called for by the legislation. “We are opening up... a very important problem,” he said. “Because it involves an immeasurable expense over 50 to 75 years, but also involves a long step toward that centralization of activities which some people call socialism.” By granting millions of ex-soldiers access to government hospitals, he suggested, communities would no longer be encouraged to collectively provide the institutions necessary to care for their neighbors. “You are throwing away... the idea of local responsibility,” he said.<sup>111</sup>

In the face of this skepticism, at least three historical circumstances paved the way for the passage of the World War Veterans’ Act. A major factor contributing to its ultimate approval and leniency was the emergence in the early to mid-1920s of what scholars have referred to as a “subgovernment,” wherein a congressional committee, veterans’ advocacy groups, and the Veterans’ Bureau formed a consolidated and highly effective political force.<sup>112</sup> In early 1924, as

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<sup>110</sup> Ibid., 558-61.

<sup>111</sup> Hearings before the Committee on World War Veterans' Legislation, House of Representatives, on Proposed Legislation as Recommended by the Director of the United States Veterans' Bureau and American Legion, Disabled American Veterans, and Veterans of Foreign Wars, 47. In a social climate of fierce anti-Communism, there was widespread appeal in employing such rhetoric in relation to the allocation of veterans’ benefits. Rosemary Stevens points out that in 1930, VB hospitals represented three percent of all hospital beds in the U.S., but the American Medical Association “presented (them) as the thin end of a wedge of a government dominated health care system” that it deemed “communistic.” Rosemary A. Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (New York: Basic Books, 1989), 127-29.

<sup>112</sup> Jeffrey M. Berry, “Subgovernments, Issue Networks, and Political Conflict,” in *Remaking American Politics*, ed. Richard A. Harris and Sidney Milkis (Boulder, Colorado: Westview Press, 1989), 239-60. For other, related secondary sources, and more on subgovernments and veterans’ advocacy, see Chapter Five of this dissertation.



the House debated whether to create a Committee on World War Veterans' Legislation, some representatives voiced concerns. Would the committee only consider legislation regarding World War veterans, even if it might affect veterans of other wars? What about the issue of hospitalization? Since the Veterans' Bureau was liable to treat former soldiers of all wars, should the new committee be tasked with overseeing all proposals regarding that agency instead of only one specific group of veterans? Proponents of the World War Veterans' Committee argued that former service members of the Civil and Spanish-American Wars already had committees where they could make their needs known, so the creation of one that would focus on World War veterans would "equalize... opportunities." Besides, according to Chairman of the House Rules Committee, Bertrand Snell (R-NY), "it is impossible to get all veterans to agree, and as we are not taking anything away from (Spanish-American War veterans), their legislation will go to the same committees it always has, we are simply now trying to help out the World War veterans." A political victory in itself, the Committee on World War Veterans' Legislation was established on January 14, 1924.<sup>113</sup> Headed by South Dakota Republican and Legionnaire Royal C. Johnson, (who had helped publicize the claims of Walter Reed patients in the months after the Armistice), it provided a sympathetic open ear and a forum for Legion-backed legislation.<sup>114</sup> The Committee gave the American Legion a clear target: the organization could coordinate its efforts to ensure that all of its proposed legislation would "be presented to Johnson's new committee," according to Legion historian Thomas A. Rumer. The World War Veterans' Act, for example, was the result of the "amalgamation of corrections, additions, and other changes" upon which advocates

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<sup>113</sup> United States Congressional Record, House, Sixty-Eighth Congress, First Session, (Washington, D.C.: Government Printing Office, January 14, 1924), 945-50. Also see Walter Stubbs, *Congressional Committees, 1789-1982* (Santa Barbara, California: A.B.C.-Clio, LLC, 1985).

<sup>114</sup> For more on Johnson's efforts on behalf of Walter Reed patients, see Chapter Three.

and committee members –some of whom were veterans and Legion members themselves – could all agree.<sup>115</sup> The existence of the Committee on World War Veterans Legislation meant that Legion officials could “concentrate their... work on relatively few legislators and staffers.”<sup>116</sup> While providing a forum for the views of representatives like Luce and Rankin, the committee showed a willingness to work through legislative proposals until they could gain the congressional backing necessary to pass.

When it came time to vote on the WWVA, committee members trumpeted the bill as a stunning accomplishment, and (as in the case of legislation establishing the VB), even those legislators who initially voiced skepticism about some details of the Bill, eventually expressed strong support for it. “I am glad today that the House of Representatives is going on record, and I doubt not practically unanimously, before the disabled men of this country to the effect, ‘Fellows, we have said in the past that nothing was too good for our disabled men, now here is what we proposed to do...’” said James MacLafferty. John Rankin assured all present that he and each member of the Committee on World War Veterans’ Legislation had worked hard on the WWVA, “actuated by a desire to do the best he could for the disabled ex-service men.” Although the bill was not perfect, these legislators argued, it went a long way in enhancing the rights of worthy veterans. Robert Luce joined his fellow committee members in a chorus of self-congratulations, “indorsing what has been said about their absolute freedom from partisanship and also testifying as to their lack of self-assertion, their anxiety to reconcile conflicting views,

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<sup>115</sup> Rumer, *The American Legion: An Official History 1919-1989*, 154-55.

<sup>116</sup> According to one scholar, the fact that Congress relies heavily on committees to formulate policies “works to the advantage of interest groups enabling them to concentrate their lobbyists’ work on relatively few legislators and staffers.” Jeffrey M. Berry; Clyde Wilcox, *The Interest Group Society, Fifth Edition* (New York, Boston, San Francisco: Pearson Education, Inc., 2009), 138.

their unanimous desire to dispense not only justice but also equity.” Like the bill establishing a Veterans’ Bureau, the WWVA passed the House with no opposing votes.<sup>117</sup>

The World War Veterans’ Act also gained favor simply by virtue of what it was not. Debated in the shadow of the highly controversial Adjusted Compensation Act, the WWVA seemed relatively innocuous. An iteration of the Bonus Bill that Harding had denounced in 1921, and that had failed to pass numerous times since the end of the war, adjusted compensation granted the soldiers and sailors of World War I the right to collect a payment in 1945 for their time in service. It was passed three weeks before the WWVA became law. The provision of a cash “bonus” for all soldiers – even those who had served just a short time – drew the ire of many who saw it as “class legislation.”<sup>118</sup> But access to hospital care was a much less divisive issue. In his State of the Union address in December 1923, President Coolidge unapologetically noted that he did not “favor the granting of a bonus,” but recommended “that all hospitals be authorized at once to receive and care for, without hospital pay, the veterans of all wars needing such care, whenever there are vacant beds, and that immediate steps be taken to enlarge and build new hospitals to serve all such cases.”<sup>119</sup> Legislators, for their part, were relieved that the World War Veterans’ Act was virtually uncontroversial, as opposed to legislation surrounding

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<sup>117</sup> United States Congressional Record, House, Sixty-Eighth Congress, First Session, (Washington, D.C.: Government Printing Office, June 2, 1924), 10171-74. Political scientists call statements like those of MacLafferty and Luce – and the general tendency of politicians to try to draw attention to their support of popular legislation – “credit claiming.” Steven S. Smith; Jason M. Roberts; Ryan J. Vander Wielen, *The American Congress, Fifth Edition* (New York, New York: Cambridge University Press, 2007), 90. My thanks to Jeffrey M. Berry, John Richard Skuse Professor of Political Science at Tufts University, for sharing his insights on this literature.

<sup>118</sup> “League of Veterans Plans to Kill Bonus,” *New York Times* June 3, 1924. “Seek Injunction to Block Bonus,” *The Atlanta Journal-Constitution* June 5, 1924. The Adjusted Compensation Act paved the way for the 1932 Bonus March and a storm of veterans’ activism. For more on this later period, see Ortiz, *Beyond the Bonus March and G.I. Bill*. Frydl, *The G.I. Bill*. Glenn C. Altschuler; Stuart M. Blumin, *The G.I. Bill: A New Deal for Veterans* (New York, New York: Oxford University Press, 2009).

<sup>119</sup> “First Annual Message of President Calvin Coolidge,” <http://www.presidency.ucsb.edu/ws/index.php?pid=29564#axzz1XqMJjKaq>.

adjusted compensation. “Those of us that took a stand for the service men recently in the matter of adjusted compensation have heard some criticism,” said James MacLafferty. “That is an open question, but, thank God, on this question there is no debate necessary.” John Rankin joined MacLafferty in his “gratification over the fact that there will not be much criticism of the members of the Veterans’ Committee.”<sup>120</sup> In a time when hospitals were only just beginning to emerge as desired sites of care, access to government medical institutions seemed to many to be a small price to pay to ensure the well-being of disabled and ill ex-soldiers. Coolidge and others could, in good conscience, support the seemingly humane ideal of providing access to state-of-the-art medical care for veterans, even as they rejected the rationale of cash payments.<sup>121</sup>

In this respect, the medical provisions of the WWVA were helped by the fact that it was difficult to comprehend the material value of providing access to hospitals for needy veterans. As one scholar notes, “organizational interests have a high probability of affecting policy outcomes when they lobby on issues about which the public and media know and care little about... when they lobby on issues that are highly technical or complex...”<sup>122</sup> Hospital care for veterans in the World War One era fit both of those criteria.

As veterans’ advocates fought for passage of the WWVA, their cause was also likely boosted by an ongoing Congressional investigation regarding corruption and embezzlement in

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<sup>120</sup> United States Congressional Record, House, 10171-2.

<sup>121</sup> For an example of the relatively favorable coverage received by the World War Veterans’ Act, see: “Better Care for Ex-Service Men to Be Provided,” *The Sun* June 11, 1924.

<sup>122</sup> Anthony J. Nownes, *Pressure and Power: Organized Interests in American Politics*, ed. Allan J. Cigler, The New Directions in Political Behavior Series (Boston, Massachusetts; New York, New York: Houghton Mifflin Company, 2001), 202-05. Nownes cites three other conditions under which organized interests have “a high probability of affecting policy outcomes: “when they face little or not opposition from other political actors... when they lobby policymakers who are undecided on an issue... (and) when they lobby on issues that are nonpartisan and nonideological.” All of these conditions existed in the early 1920s for veterans’ groups advocating for hospital care for their constituents.

the administration of the Veterans' Bureau. Released the day before the WWVA became law, a Senate report on the matter alleged, among other things, that the VB's first Director, Charles Forbes, sold government property at well below cost to personal friends and sold hospital sites at inflated prices to reap his own financial rewards. The report painted a dark picture, noting that it would "probably never be known how much money was spent for makeshift expedients..."<sup>123</sup> Many felt that this systemic failure demonstrated that veterans still had not received their fair due, and made the call for more and better benefits all the more necessary. It helped make 1924 a "banner year" for veterans, not least of all in the arena of federal entitlements.<sup>124</sup>

As it turned out, worries expressed by legislators like Rankin and Luce regarding the expansiveness of the World War Veterans' Act were more accurate than the sentiment of Hines, who thought the legislation would result in somewhat of an increase in the VB's number of patients, but that there would be a general balancing out of discharges and admissions. As a result of the passage of the World War Veterans' Act and a general expansion of rules regarding disability ratings and service-connection for various conditions, the number of patients getting hospital treatment sponsored by the VB grew from approximately 18,000 in 1924 to more than 30,000 in 1930. In 1925, one year after the passage of the Act, patients being treated for non-service connected disabilities amounted to 14 percent of the VB's hospital load. By 1930, 46 percent of all Bureau patients were receiving hospital care for non-line-of-duty injuries or illnesses. The "growing problem of hospitalization of veterans of the world and other wars, and

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<sup>123</sup> Senator David Walsh, Investigation of the United States Veterans' Bureau, Third Preliminary Report, Pursuant to S. Res. 466, 67th Cong., 4th Sess., Sixty-Eighth Congress, First Session, S. Report 103, Part 3, (Washington, DC: Government Printing Office, 1924), 5. Various newspaper articles regarding mismanagement at the VB were published the day the WWVA became law. For example, see "Oddie, Adding Data, Pushes His Charges Upon Veteran 'Ring' ", *The Washington Post* June 7, 1924. "Jurors in Forbes Case Make Sealed Report," *The Washington Post* June 7, 1924.

<sup>124</sup> Pencak, *For God and Country: The American Legion 1919-1941*, 185. According to Pencak, 13 of the committee's original 21 members were A.E.F. veterans.

the necessity for the expansion of government facilities,” one Veterans’ Bureau report said, “are shown in increasing number of hospital admissions each year.”<sup>125</sup> As Robert Luce had argued, the “principle of free hospitalization for all verterans had been established,” and it was “incumbent upon the government to “furnish the facilities...”<sup>126</sup>

### Conclusion

When the VB was established in August 1921, veterans’ groups wished it to be a highly autonomous unit, answerable only to the President, and they attempted to ensure that it would be a permanent entity. Budget conscious congressional representatives, on the other hand, held out hope that it would be a temporary fix to a crisis situation. In the end, the advocates’ hopes were fulfilled. The agency’s first director, Charles R. Forbes, ensured that the new bureau would replace the Department of the Treasury as overseer of hospital building and administration, and he worked aggressively (if not always morally) to ensure that the number of veterans’ hospitals would grow under his watch. Veterans’ groups aided the cause by calling attention to the federal government’s failure to provide what they deemed an acceptable standard of medical care for former soldiers. They presented the situation as a catastrophe that could only be alleviated by former service members’ access to an unparalleled level of government assistance.

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<sup>125</sup> Annual Report of the Director of the United States Veterans' Bureau, for the Fiscal Year Ended June 30, 1930, (Washington, D.C.: Government Printing Office, 1930), 7-9. The 1930 report also noted that there was “a marked change in the character of the hospital population” since June 30, 1920, when 34 percent of the patients were being treated for tuberculosis, 29 percent for neuropsychiatric diseases, and 37 percent for general medical and surgical conditions. By 1930, there had been a huge spike in patients receiving neuropsychiatric care: they made up 49 percent of all patients. Another 21 percent were being treated for tuberculosis and 30 percent for general medical conditions. By 1930, there had also been tremendous growth in the number of patients being hospitalized for non-line-of-duty disabilities: they made up 46 percent of all Bureau patients (as opposed to just 14 percent five years earlier, in 1925).

<sup>126</sup> Hearings before the Committee on World War Legislation, House of Representatives, on Proposed Legislation as Recommended by the Director of the United States Veterans' Bureau, the Amerian Legion, Disabled American Veterans, and Veterans of Foreign Wars, and H.R. 7320, Part 2, 556.

Advocates cited the pragmatically appealing twin goals of administrative efficiency and fiscal responsibility in order to convince Congress to establish the Veterans' Bureau, and later, to extend health services to all veterans, not just those who had incurred their disabilities or illnesses in the line of duty. They fought for their demands based on the fact that the current situation was unacceptable. Anything, they argued, was better than sick or hurt veterans being treated in unsuitable institutions, or worse, having to wait to be treated at all; immediate change, they urgently noted, was necessary. When the World War Veterans' Act was passed in 1924 stipulating that all veterans could have access to publicly sponsored hospital care, it became clear that the Veterans' Bureau would continue on a growth trajectory. The government would, for an indefinite period, grant a distinct and increasingly valuable welfare privilege to former service members.

## POSTSCRIPT

### **“No End of Trouble”: Conditional, fluctuating privileges, and the legacy of Great War health policy<sup>1</sup>**

Lieutenant Frank Schoble, Jr. used few words to convey the gravity of his feelings. “One day I was a man amply able to take care of myself,” he told the Philadelphia Rotary Club in the fall of 1920. “The next morning I was a piece of baggage – something to be taken care of.”

Schoble’s dual realities represented his perspectives before and after the Meuse-Argonne Offensive, the bloodiest operation undertaken by the American Expeditionary Forces during World War I. One of approximately 100,000 American troops wounded in a campaign that stretched from late September through the signing of the Armistice on November 11, 1918, Schoble was blinded in battle.<sup>2</sup>

The soldier’s initial feelings of utter hopelessness relented, he reported, as “everything that a grateful government and self-sacrificing individual welfare workers could think of to make me a self-supporting citizen was placed at my disposal.”<sup>3</sup>

Schoble’s account encapsulated a primary hope of the army and government; that injured soldiers would be rehabilitated quickly and efficiently – ideally, before being discharged from the military – and contentedly resume their duties as fathers, sons, brothers, and workers. Indeed, Schoble’s testimony demonstrates that, in many ways, the U.S. government prepared for the

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<sup>1</sup> The quote is from John D. Kirchenstein, "Army Services Experience Questionnaire, 1914-1921", 76. World War I Veterans' Survey, 15th Field Artillery Regiment, Division 1-20, Army Heritage and Education Center, U.S. Military History Institute Archives, Carlisle Barracks, Carlisle, PA.

<sup>2</sup> On Meuse-Argonne, see Robert H. Ferrell, *America's Deadliest Battle: Meuse-Argonne, 1918* (Lawrence, Kansas: University Press of Kansas, 2007).

<sup>3</sup> "Sightless Veteran Says Blindness Is a Privilege," *The Come-Back* October 16, 1920



health outcomes of the Great War more comprehensively than it had for any other previous conflict.

But Frank Schoble's experience was far from the norm. The "grateful government" often faltered, and not all veterans found themselves quite so satisfied. John D. Kirchenstein made numerous appeals to the Public Health Service and, later, the Veterans' Bureau for cash benefits and medical care to alleviate the effects of a mustard gas burn to the lungs that he claimed led to chronic coughing and caused him to miss work often. Even with the notarized affidavits of fellow troops, who verified that he had been the victim of a gas attack near Chatteu-Thierry in the summer of 1918, and of doctors, who confirmed that he had been treated since his discharge from the military in 1919 for chronic lung conditions likely caused by gas, his application for benefits – including repayment for a \$150.00 hospital bill – were repeatedly denied. "The mustard gas burn which my husband received is giving no end of trouble now," his wife wrote to a friend in April 1931. "He certainly is entitled to compensation, but because there is not a record of it on his medical report, they have no proof of it."<sup>4</sup>

Fellow veterans who, like Kirchenstein, sustained injuries that were less visible than Schoble's, faced similar challenges. Looking back on his experience in the war, Harold Lafferty noted that, although his military record contained no evidence that he sustained any injury during the war, his service led to "nervous facial twitches" that likely contributed to a later onset of "mental problems."<sup>5</sup> Edmond Sorenson, recounted a story similar to Kirchenstein's. "I was gassed in France – had lung troubles later, which persisted for a long time – applied for educational benefits after discharge, but was turned down, not of service origin. I needed it badly

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<sup>4</sup> Kirchenstein, "Army Services Experience Questionnaire, 1914-1921".

<sup>5</sup> Harold A. Lafferty, "Army Service Experiences Questionnaire, 1914-1921", *Ibid.* 149th Field Artillery, Division 26-42,

but went to work and made it in spite of this – wasn't easy.”<sup>6</sup> The claims of Kirchenstein, Lafferty and Sorenson make it clear that even with the passage of legislation in the early 1920s guaranteeing expanded benefits, government assistance was not always forthcoming.

Throughout the twentieth and twenty-first centuries, the veterans' health system experienced both challenges and successes. Within just a decade of the establishment of the Veterans' Bureau, the United States was steeped in the Great Depression, and President Franklin D. Roosevelt, among others, called the very idea of a veterans' benefits system into question. In an effort to reign in spending, Roosevelt proposed the Economy Act, which would preclude the more than 30,000 ex-service men with non-service-connected disabilities from receiving care at veterans' hospitals. Facing a cacophony of opposition from the American Legion, the Veterans of Foreign Wars, and other groups, the stipulations in the legislation regarding medical care were quickly reversed. As a result of the activism generated by opposition to Roosevelt's plan, veterans' benefits were not only restored, but, by the mid-1930s, somewhat enhanced.<sup>7</sup>

Even after the Veterans' Bureau, the Bureau of Pensions, and the National Home for Disabled Volunteer Soldiers were consolidated into the Veterans Administration (VA) in 1930, however, the veterans' hospital system remained a “backwater,” as scholar Paul Starr puts it. After World War II, when public concern for former service members was reignited, veterans'

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<sup>6</sup> Edmond D. Sorenson, "Army Services Experience Questionnaire, 1914-1921", Ibid. 7th Sanitary Train, Division 1-20,

<sup>7</sup> For a detailed look at the Economy Act and its effect on veterans' benefits and access to medical care, see Mitchel B. Wallerstein, "Terminating Entitlements: Veterans' Disability Benefits in the Depression," *Policy Sciences* Vol. 7, no. No. 2 (June 1976). For a careful analysis of the interaction between FDR and veterans' groups, see Stephen R. Ortiz, *Beyond the Bonus March and G.I. Bill* (New York, New York: New York University Press, 2010). Ortiz cites helpful sources on the Economy Act and fiscal conservatism in the FDR administration. Also see Frank Friedel, *Franklin D. Roosevelt: A Rendezvous with Destiny* (Boston, Massachusetts: Back Bay Books, 1991), 237-54; 448-553. James E. Sargent, *Roosevelt and the Hundred Days: Struggle for the Early New Deal* (New York, New York: Garland Publishing, 1981). Kelly McMichael Scott, "F.D.R., Lewis Douglas, and the Raw Deal," *Historian* Vol. 63, Issue 1 (September 2000). Julian Zelizer, "The Forgotten Legacy of the New Deal: Fiscal Conservatism and the Roosevelt Administration, 1933-1938," *Presidential Studies Quarterly* Vol. 30, Issue 2 (2000).

hospitals gained more federal attention and funding, and began affiliating with medical schools.<sup>8</sup> By the mid-twentieth century, the system had grown exponentially – it consisted of hospitals, nursing homes, ambulatory care, education and training for medical professionals and research – but it failed to shake its negative reputation among veterans and many others. Indeed, in the early 1970s, in the wake of the Vietnam War, the majority of veterans eligible for care through the VA opted not to access it.<sup>9</sup>

In the late twentieth century, as medical costs in the private sector increased unabated and more Americans found themselves without insurance, the VA system underwent major reform. In the 1970s, VA doctors pioneered an electronic health record system that continues to serve as a model for private sector institutions.<sup>10</sup> And in the mid-1990s, the cumbersome administrative set-up of the Veterans Health Administration – the health service sector of the VA – was reorganized in an attempt to make services more accessible to non-indigent veterans and those with non-service-connected disabilities. Instead of maintaining an “anachronistic” “hospital-centric focus,” the VHA arranged for 23 regional “integrated service networks,” consisting of a variety of types of in- and out-patient facilities. In the wake of those organizational

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<sup>8</sup> Paul Starr, *The Discarded Army: Veterans after Vietnam; the Nader Report on Vietnam Veterans and the Veterans Administration* (New York: Charterhouse, 1974), 76. ———, *The Social Transformation of American Medicine* (New York: Basic Books, 1982), 348.

<sup>9</sup> Karen Cleary Adelman and Sar A. Levitan, *Old Wars Remain Unfinished; the Veteran Benefits System* (Baltimore: Johns Hopkins University Press, 1973), 76.

<sup>10</sup> According to Adam Oliver, the VA’s electronic health record (EHR) “is remarkable in the level of detail it provides on, for example, medical charting, providers’ orders, and patients’ progress notes. The EHR is accessible and largely integrated across the whole health care system, so that a physician can look at a patient’s records in his or her office and, in theory, on a laptop computer at the patient’s bedside.” That contrasts sharply with medical practice outside of the VHA, wherein 20 percent of medical tests must be repeated due to lost records. Adam Oliver, “The Veterans Health Administration: An American Success Story?,” *The Milbank Quarterly* Vol. 85, no. No. 1 (2007): 19. For more on VA health records as a model, see Phillip Longman, *Best Care Anywhere: Why V.A. Health Care Is Better Than Yours* (Sausalito: PoliPointPress, 2007). Robert M. Kolodner, *Computerizing Large Integrated Health Networks: The V.A. Success*

(New York, New York: Springer-Verlag, 1997).

improvements, the number of veterans eligible for care rose sharply in the early twenty-first century as the U.S. engaged in two lengthy wars in Iraq and Afghanistan. As a result, legislators increasingly called for “tighter eligibility criteria (and) re-restricting the VHA entirely to the poor and those with service-related disabilities”<sup>11</sup>

### *The Legacy of World War I era policies*

World War I era policies surrounding medical care for soldiers and veterans, then, did not bring about unyielding progress, but their legacy is lasting and profound. The legislation and activism of the Great War years provided a sturdy building block for something government officials and the general public hardly envisioned, and something that remains intact to this day: a vast, federally-sponsored hospital system geared at the needs of veterans. Throughout its more than 90 years of existence, the veterans’ health system has not always been a model of efficiency and quality, but battles fought in the interwar years established the fact that it was both worthy and necessary.

How did such a system come to be in the wake of World War I? After all, in 1917, when legislators, doctors and government officials attempted to plan for the rehabilitation of the war-wounded, they hoped to defend against long-term obligations – monetary or otherwise – to ex-service members. But their efforts were unsuccessful for various reasons. Pre-war policies made the military medical system responsible for the rehabilitation project, but also left the government liable if the system failed. Army rehabilitation efforts were plagued by vague policies that stipulated that the military should hold control of cases until “maximum curative

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<sup>11</sup> Oliver, "The Veterans Health Administration: An American Success Story?," 17, 24-25.

results” could be attained.<sup>12</sup> The army medical system was ultimately not ideologically or physically suited to fulfill this poorly defined mandate. As it became clear that soldiers’ needs went beyond the resources the military could provide, and that they expected the government to provide a financial and medical safety net until they felt they could support themselves and their families, Congress declared that pre-existing government entities – the Public Health Service, the Federal Board for Vocational Education, and the Bureau of War Risk Insurance – would oversee ex-soldiers’ care. But in spite of receiving millions of dollars in funding, and repeated attempts at legislative coordination, the problem of “divided authority” prevented these offices from effectively serving former service members. Veterans’ advocacy groups ensured that the failure did not go unrecognized. Capitalizing on the social turbulence of the time by employing hyper-patriotic rhetoric, they ceaselessly demanded three things: funding for a vast veterans’ hospital system; a powerful new government bureaucracy that would oversee the institutions and ensure the proper administration of all veterans’ benefits; and, finally, the admission of all honorably discharged ex-soldiers to veterans’ hospitals.

The health fallout from the Great War, and the advocacy work that followed, led to a vast expansion of veterans’ rights and privileges. Beginning after the Great War, former service members could obtain not only disability compensation and pension payments, but also access to a distinct system of government sponsored medical care.

That right became increasingly valuable over time. Only a few select groups in the United States won access to government-sponsored health care in the twentieth century: military personnel and veterans; American Indians (through the Indian Health Service); the poor (through

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<sup>12</sup> The quote is from "Council of National Defense General Medical Board Meeting Minutes, September 9, 1917", 5. Council of National Defense, Record Group 62, Box 426, General Medical Board, Secretary’s Office, National Archives and Records Administration, College Park, Maryland.

Medicaid); and the elderly (through Medicare). Legislation establishing mini systems of government sponsored health care and insurance has been passed on both practical and ideological grounds: practically, American Indians, veterans, the elderly, and the poor were each thought to be potentially heavy medical burdens, who were less likely than others to be able to afford the costs of care. Ideologically, advocates maintained that members of each of those constituencies were somewhat helpless; they were rightful recipients of aid from their fellow citizens. Although opponents repeatedly fought against these justifications and attempted to prove that the state was over-reaching, Americans were won over to legislation expanding government involvement in health care by arguments regarding constituents' practical needs, and their worthiness of privileges. If the United States remained the only developed nation without a system of national health insurance throughout the twentieth century, its government nevertheless provided limited assistance in making health care accessible – albeit hesitantly, conditionally, and only for select groups of citizens.

The Affordable Care Act, signed by President Barack Obama in March 2010, marks a departure in American social policy, in part, because its proponents cannot point to one specific group as a central and worthy beneficiary. To the contrary, supporters of the Affordable Care Act have presented it as a means by which the government can help *all* ordinary Americans access health insurance and, by extension, health care. Time will tell if it, like the veterans' hospital system rooted in the World War I era, will prove to be a lasting element of an ever-changing American welfare state.

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